

3681

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 DAY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>IONA</u> Middle Last <u>Baker</u>				4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-1892</u>		9. AGE (In years last birthday) <u>66</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN W. BYRD</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH BYRD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-16-4910</u>		INFORMANT Address <u>Crane Knight - Hollywood Va</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-12</u> , 19 <u>59</u> , to <u>3-12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-12</u> , 19 <u>59</u> , and that death occurred at <u>9:30 P-M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Potts</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Md. 3-13-59</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Byrd Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hollywood, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Marvel Co - Delmar, Del</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>MAR 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinner</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF VITAL RECORDS

1908

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03674

3682

Item 9 FilmG240 3-30-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> <u>19X-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles William Ballard</u>		4. DATE OF DEATH <u>3-18-1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/19/1919</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LOBAR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FUNERAL HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME <u>CHARLES BALLARD</u>		14. MOTHER'S MAIDEN NAME <u>MAGIE MORRIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MAGIE BALLARD</u>		Address <u>PRINCESS ANNE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> <u>982X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stab wound of ascending aorta</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>25 min.</u> <u>25 min.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stabbed by brother during a fight.</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:20 P.M. 3-18-59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Beer Tavern.</u>		20f. (City or town) <u>Princess Anne Somerset</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-23-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	22d. LOCATION (City, town, or county) (State) <u>Princess Anne, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>WILLIAM H. JAMES JR. PRINCESS ANNE, MD</u>		24a. REC'D BY REGISTRAR <u>26 MAR 26 59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. Smith</u>

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3002

NEW STATE
HEALTH DEPT

PLACE OF DEATH
- HOME -

DATE OF DEATH

DECEASED

RESIDENT OF

DECEASED

DECEASED

AGE

SEX

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 12 Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen Gen Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury d. STREET ADDRESS 119 A. South Division St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle FRANKLIN Last BAYSINGER		4. DATE OF DEATH Month MARCH Day 14th Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1905
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 5 Days 14 Hours 14 Min.	11. IF UNDER 24 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Medina Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank W. Baysinger		14. MOTHER'S MAIDEN NAME Alice C. Haun	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.#II		16. SOCIAL SECURITY NO. 220-09-9889	
17. INFORMANT Mr. Melvin Disharoon (Nephew-Trustee)		304 Park Heights Ave. Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion - 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		DATE SIGNED March 16 /1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 17, 1959	
22c. NAME OF CEMETERY OR CREMATORY Buckingham Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR MAR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Haun	

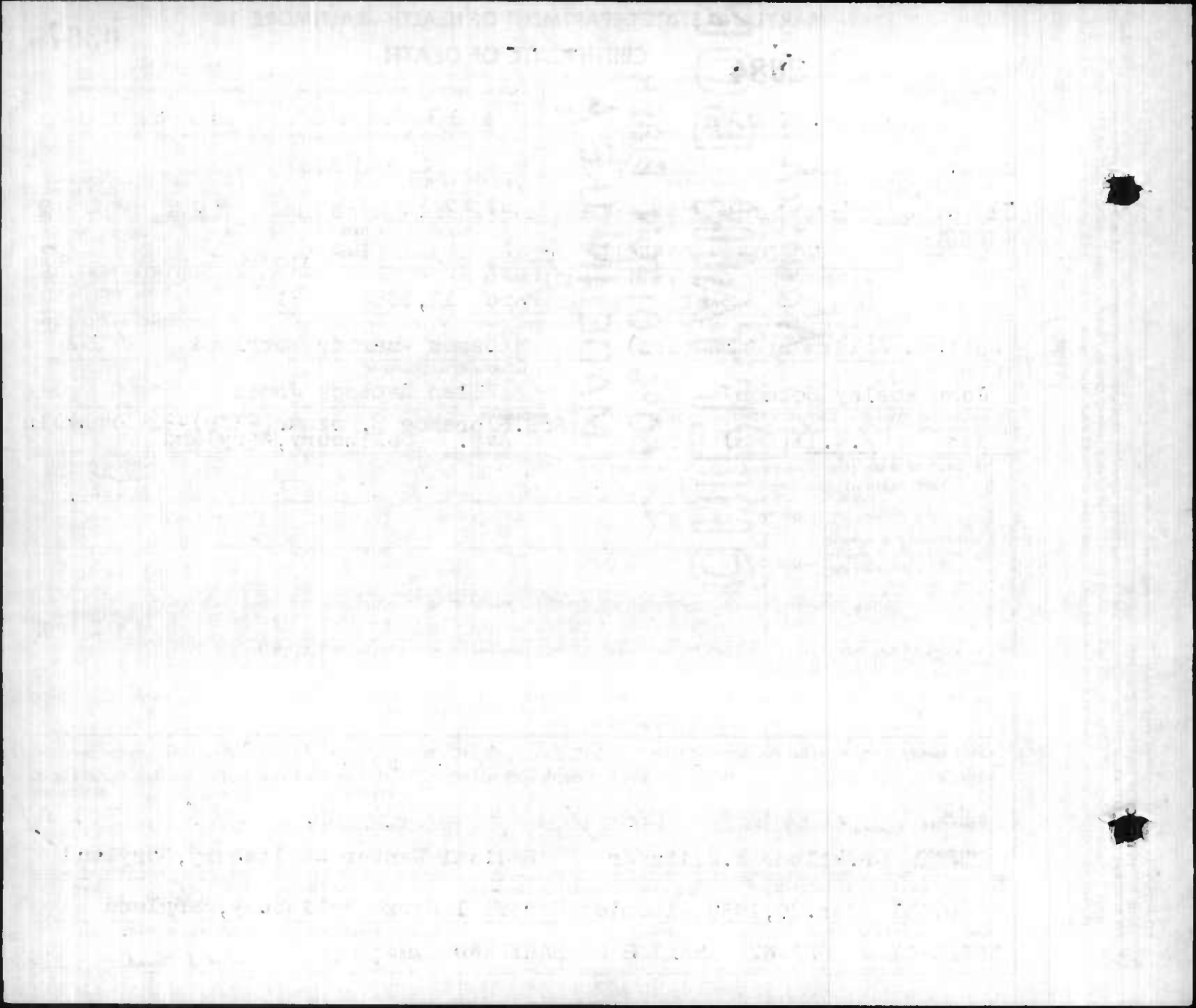
CERTIFICATE OF DEATH

Reg. Dist. No.

3684

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>1 DAY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WOODIE CARROLL Bozman</u>				4. DATE OF DEATH Month Day Year <u>MARCH 17 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1888</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman (Furniture)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (State or foreign country) <u>Dames Quarter Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Wesley Bozman</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Rebecca Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>W.W. 1X (One)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-17</u> , 19 <u>59</u> , to <u>3-17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-17</u> , 19 <u>59</u> , and that death occurred at <u>8:00 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilber R. Ellis Jr</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>3-17-59</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis Jr</u>				Medical Center - Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 20, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 19 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03677

3685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 37 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bertha Middle L. Last Bradford				4. DATE OF DEATH Month March Day 5 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1886	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland (Worcester Co.) USA	
13. FATHER'S NAME Isiah Powell				14. MOTHER'S MAIDEN NAME Sarah Timmons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ronnie Kelly Mumford (Daughter) Address R.D.#1 Pittsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease 443X DUE TO disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity							INTERVAL BETWEEN ONSET AND DEATH Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 27, 19 59 , to March 5, 19 59 , that I last saw the deceased alive on March 5, 19 59 , and that death occurred at 2:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 3/5/59							
ACTUAL SIGNATURE L. V. Maldve				M.D. Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 8, 1959		22c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery		22d. LOCATION (City, town, or county) (State) Worcester Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE MAR 10 1959	
				24b. REGISTRAR'S SIGNATURE C. J. ...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3686

Item 8 FilmG241 4-7-59 et

03678

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Selbyville 46X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Dennis Middle Brasure Last Brasure			4. DATE OF DEATH Month 3- Day 19- Year 1959		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 9 1931		9. AGE (In years last birthday) yrs. 28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) DELAWARE	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William J. Brasure			14. MOTHER'S MAIDEN NAME Ethel Collins		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT William J. Brasure Selbyville Dela Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X Interstitial Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour — o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried 3/21/59		22b. DATE THEREOF 3/21/59		22c. NAME OF CEMETERY OR CREMATORY Rosana	
22d. LOCATION (City, town, or county) Rosana Delaware		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Watson & Gray Frankford Dela		ADDRESS 9VVVVVVVVVV		24a. REC'D BY REGISTRAR DATE APR 3 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

MEDICAL CERTIFICATION

2

82

1

LABORATORY
FEE

NO. 100

DATE OF EXAMINATION

NAME OF PATIENT

AGE

SEX

DATE

11

PHYSICIAN'S SIGNATURE

TEST RESULTS

TEST RESULTS

TEST RESULTS

TEST RESULTS

TEST RESULTS

TEST RESULTS

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TEST RESULTS

3744

CERTIFICATE OF DEATH

03673

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>RFD</u>	
3. NAME OF DECEASED (Type or print) <u>Alvin</u> First <u>J.</u> Middle <u>Bratten</u> Last		4. DATE OF DEATH <u>March</u> Month <u>10</u> Day <u>1959</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 10, 1983</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William B Bratten</u>		14. MOTHER'S MAIDEN NAME <u>Martha J. Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-149407</u>	
17. INFORMANT <u>Kate Bratten</u>		Address <u>Willards Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Dilated Heart</u> <u>593X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Chronic Brights</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Oct 1958</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct</u> , 1958, to <u>Mar 10</u> , 1959, that I last saw the deceased alive on <u>Mar 5</u> , 1959, and that death occurred at <u>1 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Chas R. Law</u> M.D. <u>Berens Md</u> <u>3-10-59</u> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>3-13-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bratten Family Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Willards, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley Siligadele Inc.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAR 11 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

CLASS OF DEATH		MANNER OF DEATH	
1. Natural		a. Accidental	
2. Suicide		b. Homicide	
3. Undetermined		c. Legal	
4. Other		d. Other	
5. Unknown		e. Other	
6. Other		f. Other	
7. Other		g. Other	
8. Other		h. Other	
9. Other		i. Other	
10. Other		j. Other	
11. Other		k. Other	
12. Other		l. Other	
13. Other		m. Other	
14. Other		n. Other	
15. Other		o. Other	
16. Other		p. Other	
17. Other		q. Other	
18. Other		r. Other	
19. Other		s. Other	
20. Other		t. Other	
21. Other		u. Other	
22. Other		v. Other	
23. Other		w. Other	
24. Other		x. Other	
25. Other		y. Other	
26. Other		z. Other	
27. Other		aa. Other	
28. Other		ab. Other	
29. Other		ac. Other	
30. Other		ad. Other	
31. Other		ae. Other	
32. Other		af. Other	
33. Other		ag. Other	
34. Other		ah. Other	
35. Other		ai. Other	
36. Other		aj. Other	
37. Other		ak. Other	
38. Other		al. Other	
39. Other		am. Other	
40. Other		an. Other	
41. Other		ao. Other	
42. Other		ap. Other	
43. Other		aq. Other	
44. Other		ar. Other	
45. Other		as. Other	
46. Other		at. Other	
47. Other		au. Other	
48. Other		av. Other	
49. Other		aw. Other	
50. Other		ax. Other	
51. Other		ay. Other	
52. Other		az. Other	
53. Other		ba. Other	
54. Other		bb. Other	
55. Other		bc. Other	
56. Other		bd. Other	
57. Other		be. Other	
58. Other		bf. Other	
59. Other		bg. Other	
60. Other		bh. Other	
61. Other		bi. Other	
62. Other		bj. Other	
63. Other		bk. Other	
64. Other		bl. Other	
65. Other		bm. Other	
66. Other		bn. Other	
67. Other		bo. Other	
68. Other		bp. Other	
69. Other		bq. Other	
70. Other		br. Other	
71. Other		bs. Other	
72. Other		bt. Other	
73. Other		bu. Other	
74. Other		bv. Other	
75. Other		bw. Other	
76. Other		bx. Other	
77. Other		by. Other	
78. Other		bz. Other	
79. Other		ca. Other	
80. Other		cb. Other	
81. Other		cc. Other	
82. Other		cd. Other	
83. Other		ce. Other	
84. Other		cf. Other	
85. Other		cg. Other	
86. Other		ch. Other	
87. Other		ci. Other	
88. Other		cj. Other	
89. Other		ck. Other	
90. Other		cl. Other	
91. Other		cm. Other	
92. Other		cn. Other	
93. Other		co. Other	
94. Other		cp. Other	
95. Other		cq. Other	
96. Other		cr. Other	
97. Other		cs. Other	
98. Other		ct. Other	
99. Other		cu. Other	
100. Other		cv. Other	
101. Other		cw. Other	
102. Other		cx. Other	
103. Other		cy. Other	
104. Other		cz. Other	
105. Other		da. Other	
106. Other		db. Other	
107. Other		dc. Other	
108. Other		dd. Other	
109. Other		de. Other	
110. Other		df. Other	
111. Other		dg. Other	
112. Other		dh. Other	
113. Other		di. Other	
114. Other		dj. Other	
115. Other		dk. Other	
116. Other		dl. Other	
117. Other		dm. Other	
118. Other		dn. Other	
119. Other		do. Other	
120. Other		dp. Other	
121. Other		dq. Other	
122. Other		dr. Other	
123. Other		ds. Other	
124. Other		dt. Other	
125. Other		du. Other	
126. Other		dv. Other	
127. Other		dw. Other	
128. Other		dx. Other	
129. Other		dy. Other	
130. Other		dz. Other	
131. Other		ea. Other	
132. Other		eb. Other	
133. Other		ec. Other	
134. Other		ed. Other	
135. Other		ee. Other	
136. Other		ef. Other	
137. Other		eg. Other	
138. Other		eh. Other	
139. Other		ei. Other	
140. Other		ej. Other	
141. Other		ek. Other	
142. Other		el. Other	
143. Other		em. Other	
144. Other		en. Other	
145. Other		eo. Other	
146. Other		ep. Other	
147. Other		eq. Other	
148. Other		er. Other	
149. Other		es. Other	
150. Other		et. Other	
151. Other		eu. Other	
152. Other		ev. Other	
153. Other		ew. Other	
154. Other		ex. Other	
155. Other		ey. Other	
156. Other		ez. Other	
157. Other		fa. Other	
158. Other		fb. Other	
159. Other		fc. Other	
160. Other		fd. Other	
161. Other		fe. Other	
162. Other		ff. Other	
163. Other		fg. Other	
164. Other		fh. Other	
165. Other		fi. Other	
166. Other		fj. Other	
167. Other		fk. Other	
168. Other		fl. Other	
169. Other		fm. Other	
170. Other		fn. Other	
171. Other		fo. Other	
172. Other		fp. Other	
173. Other		fq. Other	
174. Other		fr. Other	
175. Other		fs. Other	
176. Other		ft. Other	
177. Other		fu. Other	
178. Other		fv. Other	
179. Other		fw. Other	
180. Other		fx. Other	
181. Other		fy. Other	
182. Other		fz. Other	
183. Other		ga. Other	
184. Other		gb. Other	
185. Other		gc. Other	
186. Other		gd. Other	
187. Other		ge. Other	
188. Other		gf. Other	
189. Other		gg. Other	
190. Other		gh. Other	
191. Other		gi. Other	
192. Other		gj. Other	
193. Other		gk. Other	
194. Other		gl. Other	
195. Other		gm. Other	
196. Other		gn. Other	
197. Other		go. Other	
198. Other		gp. Other	
199. Other		gq. Other	
200. Other		gr. Other	
201. Other		gs. Other	
202. Other		gt. Other	
203. Other		gu. Other	
204. Other		gv. Other	
205. Other		gw. Other	
206. Other		gx. Other	
207. Other		gy. Other	
208. Other		gz. Other	
209. Other		ha. Other	
210. Other		hb. Other	
211. Other		hc. Other	
212. Other		hd. Other	
213. Other		he. Other	
214. Other		hf. Other	
215. Other		hg. Other	
216. Other		hh. Other	
217. Other		hi. Other	
218. Other		hj. Other	
219. Other		hk. Other	
220. Other		hl. Other	
221. Other		hm. Other	
222. Other		hn. Other	
223. Other		ho. Other	
224. Other		hp. Other	
225. Other		hq. Other	
226. Other		hr. Other	
227. Other		hs. Other	
228. Other		ht. Other	
229. Other		hu. Other	
230. Other		hv. Other	
231. Other		hw. Other	
232. Other		hx. Other	
233. Other		hy. Other	
234. Other		hz. Other	
235. Other		ia. Other	
236. Other		ib. Other	
237. Other		ic. Other	
238. Other		id. Other	
239. Other		ie. Other	
240. Other		if. Other	
241. Other		ig. Other	
242. Other		ih. Other	
243. Other		ii. Other	
244. Other		ij. Other	
245. Other		ik. Other	
246. Other		il. Other	
247. Other		im. Other	
248. Other		in. Other	
249. Other		io. Other	
250. Other		ip. Other	
251. Other		iq. Other	
252. Other		ir. Other	
253. Other		is. Other	
254. Other		it. Other	
255. Other		iu. Other	
256. Other		iv. Other	
257. Other		iw. Other	
258. Other		ix. Other	
259. Other		iy. Other	
260. Other		iz. Other	
261. Other		ja. Other	
262. Other		jb. Other	
263. Other		jc. Other	
264. Other		jd. Other	
265. Other		je. Other	
266. Other		jf. Other	
267. Other		jg. Other	
268. Other		jh. Other	
269. Other		ji. Other	
270. Other		jj. Other	
271. Other		jk. Other	
272. Other		jl. Other	
273. Other		jm. Other	
274. Other		jn. Other	
275. Other		jo. Other	
276. Other		jp. Other	
277. Other		jq. Other	
278. Other		jr. Other	
279. Other		js. Other	
280. Other		jt. Other	
281. Other		ju. Other	
282. Other		jv. Other	
283. Other		jw. Other	
284. Other		jx. Other	
285. Other		jy. Other	
286. Other		jz. Other	
287. Other		ka. Other	
288. Other		kb. Other	
289. Other		kc. Other	
290. Other		kd. Other	
291. Other		ke. Other	
292. Other		kf. Other	
293. Other		kg. Other	
294. Other		kh. Other	
295. Other		ki. Other	
296. Other		kj. Other	
297. Other		kk. Other	
298. Other		kl. Other	
299. Other		km. Other	
300. Other		kn. Other	
301. Other		ko. Other	
302. Other		kp. Other	
303. Other		kq. Other	
304. Other		kr. Other	
305. Other		ks. Other	
306. Other		kt. Other	
307. Other		ku. Other	
308. Other		kv. Other	
309. Other		kw. Other	
310. Other		kx. Other	
311. Other		ky. Other	
312. Other		kz. Other	
313. Other		la. Other	
314. Other		lb. Other	
315. Other		lc. Other	
316. Other		ld. Other	
317. Other		le. Other	
318. Other		lf. Other	
319. Other		lg. Other	
320. Other		lh. Other	
321. Other		li. Other	
322. Other		lj. Other	
323. Other		lk. Other	
324. Other		ll. Other	
325. Other		lm. Other	
326. Other		ln. Other	
327. Other		lo. Other	
328. Other		lp. Other	
329. Other		lq. Other	
330. Other		lr. Other	
331. Other		ls. Other	
332. Other		lt. Other	
333. Other		lu. Other	
334. Other		lv. Other	
335. Other		lw. Other	
336. Other		lx. Other	
337. Other		ly. Other	
338. Other		lz. Other	
339. Other		ma. Other	
340. Other		mb. Other	
341. Other		mc. Other	
342. Other		md. Other	
343. Other		me. Other	
344. Other		mf. Other	
345. Other		mg. Other	
346. Other		mh. Other	
347. Other		mi. Other	
348. Other		mj. Other	
349. Other		mk. Other	
350. Other		ml. Other	
351. Other		mo. Other	
352. Other		mp. Other	
353. Other		mq. Other	
354. Other		mr. Other	
355. Other		ms. Other	
356. Other		mt. Other	
357. Other		mu. Other	
358. Other		mv. Other	
359. Other		mw. Other	
360. Other		mx. Other	
361. Other		my. Other	
362. Other		mz. Other	
363. Other		na. Other	
364. Other		nb. Other	
365. Other		nc. Other	
366. Other		nd. Other	
367. Other		ne. Other	
368. Other		nf. Other	
369. Other		ng. Other	
370. Other		nh. Other	
371. Other		ni. Other	
372. Other		nj. Other	
373. Other		nk. Other	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>8 DAYS</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>VIANNA</u> Middle <u>B.</u> Last <u>Byrd</u>			4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1959</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>MAY 7, 1931</u>		9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BEAUTICIAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>BEAUTY SHOP</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>STANLEY BACALL</u>		
14. MOTHER'S MAIDEN NAME <u>VIANNA TATMAN</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> If yes, give war or dates of service <u>—</u>		
16. SOCIAL SECURITY NO. <u>218-24-4994C</u>			17. INFORMANT <u>AMES BYRD, Pocomoke City, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural Hematoma secondary to (c) (non-traumatic)</u> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Monocytic Leukemia</u> DUE TO (c) <u>8 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12 hrs</u> INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>3/20</u> , 19 <u>59</u> , to <u>3/28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/28</u> , 19 <u>59</u> , and that death occurred at <u>1:25</u> P.M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.			ADDRESS (Street, city or town, state) <u>PINEBLUFF Rd. SALISBURY, Md.</u>		
DATE SIGNED <u>3/28/59</u>			PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-31-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SALEM METHODIST</u>	
22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>Pocomoke City, Md.</u>			
24a. REGISTRY REGISTRAR <u>APR 1 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature

DATE OF EXAMINATION

Signature of Examiner

Signature of Registrar

Signature of Medical Officer

Signature of Coroner

Signature of

Signature of

Signature of

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03681

3688

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>				c. LENGTH OF STAY IN 1b <u>1 mo. 2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> <u>23x-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>CHAIRES</u> Last <u>Calder</u>				4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/26/1892</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Showell, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John M. Ryan</u>				14. MOTHER'S MAIDEN NAME <u>Ana Daisey Campbell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>				16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Hospital Records, Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis with left hemiplegia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u>Arteriosclerosis, general</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>unk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Feb. 12</u> , 19 <u>59</u> , to <u>March 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 13</u> , 19 <u>59</u> , and that death occurred at <u>1:00A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Kosmahly</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
DATE SIGNED <u>3/14/59</u>							
PHYSICIAN'S NAME (Type) <u>Gerhard Kosmahly, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Amos D. Burboye</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>MAR 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10

100

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03682

3689

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		23X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R F D # 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edgar S Carmean</u>				4. DATE OF DEATH Month Day Year <u>3-21-1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-1875</u>		9. AGE (In years last birthday) <u>83 yrs.</u>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Willard S. Carmean</u>				14. MOTHER'S MAIDEN NAME <u>Essie Mae Parsons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Clifford Duffey, Salisbury, Md</u> Address <u>287 Snow Hill Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic cardio-vascular disease</u> years DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured right hip.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in own home.</u>					
20c. TIME OF INJURY Month, Day, Year <u>P.M. 3-13-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>own home</u>		20f. (City or town) (County) (State) <u>Snow Hill Worcester Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-23-59</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bates Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay & Sumner</u>				ADDRESS <u>Snow Hill, Md</u>		24. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	
25. REC'D BY REGISTRAR DATE <u>MAR 26 '59</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

DATE OF DEATH
PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

Signature of Medical Examiner

Signature of Coroner

Signature of Registrar

Signature of Clerk

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of Registrar

Signature of

3745

CERTIFICATE OF DEATH

03683

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>				c. LENGTH OF STAY IN 1b <u>2 yrs</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EMMA S. CONWAY</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>26</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/5/1881</u>	
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>21</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>James R. Hayward</u>				14. MOTHER'S MAIDEN NAME <u>Alice Cotman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>				16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Mrs Julius Wallace, Nanticoke, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Infection</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. <u>19</u> Day. <u></u> Year. <u></u> Hour a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>2/3</u> , 19 <u>58</u> to <u>3/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/26</u> , 19 <u>59</u> , and that death occurred at <u>3 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.				ADDRESS (Street, city or town, state) <u>Nanticoke Md.</u>		DATE SIGNED <u>3/28/59</u>	
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>				<u>Nanticoke, Maryland</u>		<u>3/28/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Town Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Tveskin, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Messink</u>				ADDRESS <u>Bivalve, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 31 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kross</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

03684

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 Wrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. STREET ADDRESS 403 Dover St.,			
3. NAME OF DECEASED (Type or print) First Middle Last James Love Cooper				4. DATE OF DEATH Month Day Year 3 17 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/1959	9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months Days Hours Min. 55	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Work	
10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME B. Randolph Cooper				14. MOTHER'S MAIDEN NAME Annabelle Love			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Randolph Cooper, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal type alelectasia 762.5 DUE TO Prematurity with marked immaturity (b) (Wt 310gms) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 7 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	Month 19	Day 17	Year 19 59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Salisbury, Maryland	20g. (County) Wicomico
21. I certify that I attended the deceased from Mar 17 19 59 , to Mar 17 19 59 , that I last saw the deceased alive on Mar 17 19 59 , and that death occurred at 10:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 702 Camden Avenue DATE SIGNED Robert W. Saunderson, Jr., M.D.							
ACTUAL SIGNATURE Robert W. Saunderson, Jr., M.D.				PHYSICIAN'S NAME (Type) Robert W. Saunderson, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/18/59		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury				24a. REC'D BY REGISTRAR DATE MAR 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Norman T. Baker 2182392XVO

CERTIFICATE OF DEATH

1. NAME OF DECEASED MRS. J. M. COOPER		2. SEX Female		3. AGE 40	
4. RACE White		5. BIRTH DATE 1913		6. BIRTH PLACE Maryland	
7. DECEASED DATE 1953		8. DECEASED TIME 10:00 AM		9. DECEASED PLACE Home	
10. DECEASED CAUSE Heart Disease		11. DECEASED DISEASE Coronary Artery Disease		12. DECEASED SYMPTOMS Chest pain, shortness of breath	
13. DECEASED HISTORY Hypertension, Diabetes		14. DECEASED TREATMENT Medication, Surgery		15. DECEASED OUTCOME Death	
16. DECEASED SIGNATURE J. M. Cooper		17. DECEASED ADDRESS 123 Main St, Baltimore, MD		18. DECEASED CITY Baltimore	
19. DECEASED STATE Maryland		20. DECEASED ZIP 21201		21. DECEASED COUNTY Baltimore	
22. DECEASED DISTRICT Baltimore		23. DECEASED WARD Baltimore		24. DECEASED BLOCK Baltimore	
25. DECEASED LOT Baltimore		26. DECEASED TRACT Baltimore		27. DECEASED SUBDIVISION Baltimore	
28. DECEASED PARCEL Baltimore		29. DECEASED LOT Baltimore		30. DECEASED TRACT Baltimore	
31. DECEASED SUBDIVISION Baltimore		32. DECEASED PARCEL Baltimore		33. DECEASED LOT Baltimore	
34. DECEASED TRACT Baltimore		35. DECEASED SUBDIVISION Baltimore		36. DECEASED PARCEL Baltimore	
37. DECEASED LOT Baltimore		38. DECEASED TRACT Baltimore		39. DECEASED SUBDIVISION Baltimore	
40. DECEASED PARCEL Baltimore		41. DECEASED LOT Baltimore		42. DECEASED TRACT Baltimore	
43. DECEASED SUBDIVISION Baltimore		44. DECEASED PARCEL Baltimore		45. DECEASED LOT Baltimore	
46. DECEASED TRACT Baltimore		47. DECEASED SUBDIVISION Baltimore		48. DECEASED PARCEL Baltimore	
49. DECEASED LOT Baltimore		50. DECEASED TRACT Baltimore		51. DECEASED SUBDIVISION Baltimore	
52. DECEASED PARCEL Baltimore		53. DECEASED LOT Baltimore		54. DECEASED TRACT Baltimore	
55. DECEASED SUBDIVISION Baltimore		56. DECEASED PARCEL Baltimore		57. DECEASED LOT Baltimore	
58. DECEASED TRACT Baltimore		59. DECEASED SUBDIVISION Baltimore		60. DECEASED PARCEL Baltimore	
61. DECEASED LOT Baltimore		62. DECEASED TRACT Baltimore		63. DECEASED SUBDIVISION Baltimore	
64. DECEASED PARCEL Baltimore		65. DECEASED LOT Baltimore		66. DECEASED TRACT Baltimore	
67. DECEASED SUBDIVISION Baltimore		68. DECEASED PARCEL Baltimore		69. DECEASED LOT Baltimore	
70. DECEASED TRACT Baltimore		71. DECEASED SUBDIVISION Baltimore		72. DECEASED PARCEL Baltimore	
73. DECEASED LOT Baltimore		74. DECEASED TRACT Baltimore		75. DECEASED SUBDIVISION Baltimore	
76. DECEASED PARCEL Baltimore		77. DECEASED LOT Baltimore		78. DECEASED TRACT Baltimore	
79. DECEASED SUBDIVISION Baltimore		80. DECEASED PARCEL Baltimore		81. DECEASED LOT Baltimore	
82. DECEASED TRACT Baltimore		83. DECEASED SUBDIVISION Baltimore		84. DECEASED PARCEL Baltimore	
85. DECEASED LOT Baltimore		86. DECEASED TRACT Baltimore		87. DECEASED SUBDIVISION Baltimore	
88. DECEASED PARCEL Baltimore		89. DECEASED LOT Baltimore		90. DECEASED TRACT Baltimore	
91. DECEASED SUBDIVISION Baltimore		92. DECEASED PARCEL Baltimore		93. DECEASED LOT Baltimore	
94. DECEASED TRACT Baltimore		95. DECEASED SUBDIVISION Baltimore		96. DECEASED PARCEL Baltimore	
97. DECEASED LOT Baltimore		98. DECEASED TRACT Baltimore		99. DECEASED SUBDIVISION Baltimore	
100. DECEASED PARCEL Baltimore		101. DECEASED LOT Baltimore		102. DECEASED TRACT Baltimore	
103. DECEASED SUBDIVISION Baltimore		104. DECEASED PARCEL Baltimore		105. DECEASED LOT Baltimore	
106. DECEASED TRACT Baltimore		107. DECEASED SUBDIVISION Baltimore		108. DECEASED PARCEL Baltimore	
109. DECEASED LOT Baltimore		110. DECEASED TRACT Baltimore		111. DECEASED SUBDIVISION Baltimore	
112. DECEASED PARCEL Baltimore		113. DECEASED LOT Baltimore		114. DECEASED TRACT Baltimore	
115. DECEASED SUBDIVISION Baltimore		116. DECEASED PARCEL Baltimore		117. DECEASED LOT Baltimore	
118. DECEASED TRACT Baltimore		119. DECEASED SUBDIVISION Baltimore		120. DECEASED PARCEL Baltimore	
121. DECEASED LOT Baltimore		122. DECEASED TRACT Baltimore		123. DECEASED SUBDIVISION Baltimore	
124. DECEASED PARCEL Baltimore		125. DECEASED LOT Baltimore		126. DECEASED TRACT Baltimore	
127. DECEASED SUBDIVISION Baltimore		128. DECEASED PARCEL Baltimore		129. DECEASED LOT Baltimore	
130. DECEASED TRACT Baltimore		131. DECEASED SUBDIVISION Baltimore		132. DECEASED PARCEL Baltimore	
133. DECEASED LOT Baltimore		134. DECEASED TRACT Baltimore		135. DECEASED SUBDIVISION Baltimore	
136. DECEASED PARCEL Baltimore		137. DECEASED LOT Baltimore		138. DECEASED TRACT Baltimore	
139. DECEASED SUBDIVISION Baltimore		140. DECEASED PARCEL Baltimore		141. DECEASED LOT Baltimore	
142. DECEASED TRACT Baltimore		143. DECEASED SUBDIVISION Baltimore		144. DECEASED PARCEL Baltimore	
145. DECEASED LOT Baltimore		146. DECEASED TRACT Baltimore		147. DECEASED SUBDIVISION Baltimore	
148. DECEASED PARCEL Baltimore		149. DECEASED LOT Baltimore		150. DECEASED TRACT Baltimore	
151. DECEASED SUBDIVISION Baltimore		152. DECEASED PARCEL Baltimore		153. DECEASED LOT Baltimore	
154. DECEASED TRACT Baltimore		155. DECEASED SUBDIVISION Baltimore		156. DECEASED PARCEL Baltimore	
157. DECEASED LOT Baltimore		158. DECEASED TRACT Baltimore		159. DECEASED SUBDIVISION Baltimore	
160. DECEASED PARCEL Baltimore		161. DECEASED LOT Baltimore		162. DECEASED TRACT Baltimore	
163. DECEASED SUBDIVISION Baltimore		164. DECEASED PARCEL Baltimore		165. DECEASED LOT Baltimore	
166. DECEASED TRACT Baltimore		167. DECEASED SUBDIVISION Baltimore		168. DECEASED PARCEL Baltimore	
169. DECEASED LOT Baltimore		170. DECEASED TRACT Baltimore		171. DECEASED SUBDIVISION Baltimore	
172. DECEASED PARCEL Baltimore		173. DECEASED LOT Baltimore		174. DECEASED TRACT Baltimore	
175. DECEASED SUBDIVISION Baltimore		176. DECEASED PARCEL Baltimore		177. DECEASED LOT Baltimore	
178. DECEASED TRACT Baltimore		179. DECEASED SUBDIVISION Baltimore		180. DECEASED PARCEL Baltimore	
181. DECEASED LOT Baltimore		182. DECEASED TRACT Baltimore		183. DECEASED SUBDIVISION Baltimore	
184. DECEASED PARCEL Baltimore		185. DECEASED LOT Baltimore		186. DECEASED TRACT Baltimore	
187. DECEASED SUBDIVISION Baltimore		188. DECEASED PARCEL Baltimore		189. DECEASED LOT Baltimore	
190. DECEASED TRACT Baltimore		191. DECEASED SUBDIVISION Baltimore		192. DECEASED PARCEL Baltimore	
193. DECEASED LOT Baltimore		194. DECEASED TRACT Baltimore		195. DECEASED SUBDIVISION Baltimore	
196. DECEASED PARCEL Baltimore		197. DECEASED LOT Baltimore		198. DECEASED TRACT Baltimore	
199. DECEASED SUBDIVISION Baltimore		200. DECEASED PARCEL Baltimore		201. DECEASED LOT Baltimore	
202. DECEASED TRACT Baltimore		203. DECEASED SUBDIVISION Baltimore		204. DECEASED PARCEL Baltimore	
205. DECEASED LOT Baltimore		206. DECEASED TRACT Baltimore		207. DECEASED SUBDIVISION Baltimore	
208. DECEASED PARCEL Baltimore		209. DECEASED LOT Baltimore		210. DECEASED TRACT Baltimore	
211. DECEASED SUBDIVISION Baltimore		212. DECEASED PARCEL Baltimore		213. DECEASED LOT Baltimore	
214. DECEASED TRACT Baltimore		215. DECEASED SUBDIVISION Baltimore		216. DECEASED PARCEL Baltimore	
217. DECEASED LOT Baltimore		218. DECEASED TRACT Baltimore		219. DECEASED SUBDIVISION Baltimore	
220. DECEASED PARCEL Baltimore		221. DECEASED LOT Baltimore		222. DECEASED TRACT Baltimore	
223. DECEASED SUBDIVISION Baltimore		224. DECEASED PARCEL Baltimore		225. DECEASED LOT Baltimore	
226. DECEASED TRACT Baltimore		227. DECEASED SUBDIVISION Baltimore		228. DECEASED PARCEL Baltimore	
229. DECEASED LOT Baltimore		230. DECEASED TRACT Baltimore		231. DECEASED SUBDIVISION Baltimore	
232. DECEASED PARCEL Baltimore		233. DECEASED LOT Baltimore		234. DECEASED TRACT Baltimore	
235. DECEASED SUBDIVISION Baltimore		236. DECEASED PARCEL Baltimore		237. DECEASED LOT Baltimore	
238. DECEASED TRACT Baltimore		239. DECEASED SUBDIVISION Baltimore		240. DECEASED PARCEL Baltimore	
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247. DECEASED SUBDIVISION Baltimore		248. DECEASED PARCEL Baltimore		249. DECEASED LOT Baltimore	
250. DECEASED TRACT Baltimore		251. DECEASED SUBDIVISION Baltimore		252. DECEASED PARCEL Baltimore	
253. DECEASED LOT Baltimore		254. DECEASED TRACT Baltimore		255. DECEASED SUBDIVISION Baltimore	
256. DECEASED PARCEL Baltimore		257. DECEASED LOT Baltimore		258. DECEASED TRACT Baltimore	
259. DECEASED SUBDIVISION Baltimore		260. DECEASED PARCEL Baltimore		261. DECEASED LOT Baltimore	
262. DECEASED TRACT Baltimore		263. DECEASED SUBDIVISION Baltimore		264. DECEASED PARCEL Baltimore	
265. DECEASED LOT Baltimore		266. DECEASED TRACT Baltimore		267. DECEASED SUBDIVISION Baltimore	
268. DECEASED PARCEL Baltimore		269. DECEASED LOT Baltimore		270. DECEASED TRACT Baltimore	
271. DECEASED SUBDIVISION Baltimore		272. DECEASED PARCEL Baltimore		273. DECEASED LOT Baltimore	
274. DECEASED TRACT Baltimore		275. DECEASED SUBDIVISION Baltimore		276. DECEASED PARCEL Baltimore	
277. DECEASED LOT Baltimore		278. DECEASED TRACT Baltimore		279. DECEASED SUBDIVISION Baltimore	
280. DECEASED PARCEL Baltimore		281. DECEASED LOT Baltimore		282. DECEASED TRACT Baltimore	
283. DECEASED SUBDIVISION Baltimore		284. DECEASED PARCEL Baltimore		285. DECEASED LOT Baltimore	
286. DECEASED TRACT Baltimore		287. DECEASED SUBDIVISION Baltimore		288. DECEASED PARCEL Baltimore	
289. DECEASED LOT Baltimore		290. DECEASED TRACT Baltimore		291. DECEASED SUBDIVISION Baltimore	
292. DECEASED PARCEL Baltimore		293. DECEASED LOT Baltimore		294. DECEASED TRACT Baltimore	
295. DECEASED SUBDIVISION Baltimore		296. DECEASED PARCEL Baltimore		297. DECEASED LOT Baltimore	
298. DECEASED TRACT Baltimore		299. DECEASED SUBDIVISION Baltimore		300. DECEASED PARCEL Baltimore	

CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

Reg. Dist. No.

03685

3691

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 Hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. STREET ADDRESS 403 Dover St.,			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Love Last Cooper				4. DATE OF DEATH Month 3 Day 17 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/17/1959	
9. AGE (In years last birthday) yrs. 58		IF UNDER 1 YEAR Months 58		IF UNDER 24 HRS. Days 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Work				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME B. Randolph Cooper				14. MOTHER'S MAIDEN NAME Annabelle Love			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Randolph Cooper, Same Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Total Atelectasis 762.5 DUE TO Prematurity with Marked Immaturity (WT 430 gms) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Prematurity with Marked Immaturity (WT 430 gms) DUE TO (c) Immaturity (WT 430 gms)				INTERVAL BETWEEN ONSET AND DEATH 2 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Mar 17, 1959 , to Mar 17, 1959 , that I last saw the deceased alive on Mar 17, 1959 , and that death occurred at 10:40P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 702 Camden Avenue DATE SIGNED Robert W. Saunderson, Jr., M.D.							
ACTUAL SIGNATURE Robert W. Saunderson, Jr. M.D.				702 Camden Avenue			
PHYSICIAN'S NAME (Type) Robert W. Saunderson, Jr., M.D.				Salisbury Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/59		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE MAR 20 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Krasa	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03686

3692

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 Mo. 4 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Handy Middle Eugene Last Cox		4. DATE OF DEATH Month 3 Day 13 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 2, 1890
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 13 Days 13 Hours 19 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wholesale & Retail Produce Broker		11b. KIND OF BUSINESS OR INDUSTRY Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Franklin Cox	
14. MOTHER'S MAIDEN NAME Pricilla Twigg		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Delcie Cox Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) Sub clonal & focal hemorrhage of brain (c) of brain DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced arteriosclerosis & Hypertension		INTERVAL BETWEEN ONSET AND DEATH 32 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowning - struck from behind by car	
20c. TIME OF INJURY Month, Day, Year Hour 2-9 o. m. 1959 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at 50		20f. (City or town) Salisbury (County) Wicomico (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer		DATE SIGNED 3-16-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/17/59	
22c. NAME OF CEMETERY OR CREMATORY Siloam Cemetery		22d. LOCATION (City, town, or county) Siloam, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland Norman T. Baker		24a. REC'D BY REGISTRAR DATE MAR 19 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3693

CERTIFICATE OF DEATH

03687

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle BRYAN Last CROCKETT		4. DATE OF DEATH Month MARCH Day 25th Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1907
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR: Months 0 Days 11 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant (Owner) Grocery Store		10b. KIND OF BUSINESS OR INDUSTRY Somerset Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel Thomas Crockett		14. MOTHER'S MAIDEN NAME Ida F. Dize	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumococcal Meningitis 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Otitis Media Acute Serous DUE TO Bronchopneumonia (c) 		INTERVAL BETWEEN ONSET AND DEATH 4 das 4 das 1 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		19b. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19d. (City or town) (County) (State)	
20. I certify that I attended the deceased from Feb 3/25 , 19 58 , to March 25 , 19 59 , that I last saw the deceased alive on 3/25 , 19 59 , and that death occurred at 2:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Rufus S. Gardner, Jr. M.D.		DATE SIGNED March 28, 1959	
PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner Jr. Pine Bluff Road-Salisbury, Maryland			
21a. BURIAL, CREMATION, REMOVAL (Specify) Burial	21b. DATE THEREOF Mar. 29, 1959	21c. NAME OF CEMETERY OR CREMATORY Spring Hill Memory Gardens	21d. LOCATION (City, town, or county) (State) Salisbury, Maryland
22. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR MAR 31 '59 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03688

3694

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b <i>11 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Salisbury Mardela Springs</i>		d. STREET ADDRESS <i>RFD</i>	
4. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>82 PENINSULA General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Henry</i> Middle <i>Clarence</i> Last <i>DASHIELD</i>		4. DATE OF DEATH Month <i>MARCH</i> Day <i>28</i> Year <i>1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>NEGRO</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 15, 1887</i>
9. AGE (In years last birthday) <i>71 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>Mardela Springs, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William Dashield</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth Dashield</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>220-28-4715</i>		INFORMANT Address <i>Mrs. Pauline Dashield, Mardela Springs, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> <i>466 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>Phlebotrombosis</i> DUE TO (c) <i>cardiac</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>9:45</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Salisbury, Md. 3-28-59</i>			
ACTUAL SIGNATURE <i>William R. Ellis</i> M.D.		PHYSICIAN'S NAME (Type) <i>Salisbury, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 1, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>John Wesley Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Mardela Springs, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.J. Frampton and Son, Federalsburg, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 31 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>			

NEW YORK

STATE OF NEW YORK

CITY OF NEW YORK

DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR

NEW YORK

3695

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ACCOMACK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>83X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>HALL WOOD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>HENRY</u>		First <u>T</u> Middle <u>Davis</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 26, 1906</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY T. DAVIS</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH J. GLADDING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>		INFORMANT Address <u>MRS. INEZ L. DAVIS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>WIDE SPREAD METASTATIC CARCINOMA</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>CARCINOMA - LUNG.</u> DUE TO (c) <u>5 mos.</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>8:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. Gray Reeves</u> M.D.				ADDRESS (Street, city or town, state) <u>Medical Center; Salisbury, Md.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/12/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESSELLS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ACCOMACK VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry M. Johnson</u> ADDRESS <u>Parkway</u>				24a. REC'D BY REGISTRAR <u>MAR 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03690

3746

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Eden		c. LENGTH OF STAY IN 1b all his life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #2		d. STREET ADDRESS Route #2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Isaac Middle Henry Last Davis		4. DATE OF DEATH Month 3 Day 3 Year 1959	
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ezra Davis		14. MOTHER'S MAIDEN NAME Leuvenia King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Anna B. Davis, Eden, Md., Rt#2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO (b) Hypertension DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 3 days Indefinite			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 Feb 1959 to 3 Mar 1959 , that I last saw the deceased alive on 3 Mar 1959 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 652 W main St, 2 Mar 59 DATE SIGNED ACTUAL SIGNATURE E. A. Purnell M.D. Salisbury, Maryland PHYSICIAN'S NAME (Type) Dr. E. A. Purnell			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/1959	
22c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery		22d. LOCATION (City, town, or county) (State) Allen, Md	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Stewart Funeral Home, Salisbury, Md.		24a. REC'D BY REGISTRAR DATE MAR 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Knead			

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle HENRY Last DAVIS		4. DATE OF DEATH Month MARCH Day 3rd Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 28, 1885
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR 4 Months 5 Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (Employee of Clothing Co)		10b. KIND OF BUSINESS OR INDUSTRY Wicomico Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Elijah H. Davis		14. MOTHER'S MAIDEN NAME Mary Jane Kelley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Mrs. Carolyn D. Davis (Wife) 215 Washington St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 pulmonary edema DUE TO (b) cor pulmonale DUE TO (c) emphysema		INTERVAL BETWEEN ONSET AND DEATH 1 day. 1 yr. 5 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1956 to Mar 3, 1959 that I last saw the deceased alive on Mar 3, 1959 and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) March 4, 1959 DATE SIGNED ACTUAL SIGNATURE Dr. Earl Beardsley M.D. March 4, 1959 PHYSICIAN'S NAME (Type) Dr. Earl Beardsley Maryland Ave. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 7, 1959	22c. NAME OF CEMETERY OR CREMATORY Tyaskin Meth Cemetery	22d. LOCATION (City, town, or county) (State) Tyaskin, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR MAR 6 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hines

CERTIFICATE OF DEATH

Witness

County

City

Age

Sex

Married

Single

Occupation

Residence

Place of Birth

Cause of Death

Time of Death

Handwritten signature

Handwritten date

Physician

Witness

Filed for Record

Notary Public

03692

3697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Elmer Davis		4. DATE OF DEATH Month March Day 13 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/11/1884
9. AGE (In years last birthday) yrs. 74		10. IF UNDER 1 YEAR Months 7 Days 13 Hours 13 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland (Parsonsburg)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lynn Davis		14. MOTHER'S MAIDEN NAME Ella Kelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Willards, Maryland	
17. INFORMANT Hospital Records		18. ADDRESS Mrs. Arthur Davis	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebral vascular accidents with left 331X DUE TO hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, general DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month, Day, Year 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 18, 1959 , to March 13, 1959 , that I last saw the deceased alive on March 13, 1959 , and that death occurred at 1:55 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Kosmahly		DATE SIGNED 3/13/59	
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.		ADDRESS (Street, city or town, state) Deer's Head State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 15, 1959	
22c. NAME OF CEMETERY OR CREMATORY Perdue Cemetery		22d. LOCATION (City, town, or county) (State) Near Powellville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR DATE MAR 17 '59	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

3-10-33

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		TIME OF BIRTH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	
CERTIFICATE OF DEATH [Illegible]		CERTIFICATE OF DEATH [Illegible]		CERTIFICATE OF DEATH [Illegible]	

[Handwritten signature]

3693

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saltstary</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL Hospital</u>		d. STREET ADDRESS <u>23X-2</u>	
3. NAME OF DECEASED (Type or print) <u>First Baby Middle Shil Last DENNIS</u>		4. DATE OF DEATH <u>MARCH 1-1959</u> Month <u>1-1</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 1-1959</u>
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR <u>2</u> Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Saltstary, md</u>		12. CITIZEN OF WHAT COUNTRY? <u>None</u>	
13. FATHER'S NAME <u>Sidney DENNIS</u>		14. MOTHER'S MAIDEN NAME <u>Purnell Dorothy Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Helen Taylor, Snow Hill, md</u>		Address <u>Rural #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Prematurity</u> DUE TO (c) <u>Premature Separation of the Placenta</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/1</u> , 19 <u>59</u> , to <u>3/1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/1</u> , 19 <u>59</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John M. Bender</u> M.D. <u>104 Bay St. Snow Hill, md.</u> <u>3/2/59</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>John M. Bender M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>March 3/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>md West County</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne J. Smith</u> ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR <u>MAR 3 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2052161XVO

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

DEATH CERTIFICATE

FILE NO. 100-100000

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9, Film G241, 4/10/59
3699
CERTIFICATE OF DEATH

03694

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>23 yrs.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EAST COLLEGE AVE</u>		d. STREET ADDRESS <u>EAST COLLEGE AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RATIE</u> Middle <u>R.</u> Last <u>DISHAROOM</u>		4. DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William J. Sterling</u>		14. MOTHER'S MAIDEN NAME <u>Alfena Bennett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wm. Charles Howard - Salisbury, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction (Acute)</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arterio Sclerotic Cardio Vascular disease</u> DUE TO (c) <u>30 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>211 Maryland Ave.</u>	
PHYSICIAN'S NAME (Type) <u>O. J. Burton, M.D.</u>		<u>Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-13-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sunny Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Crusfield, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Gannell Co - Salisbury, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>MAR 19 59</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

CERTIFICATE OF DEATH

BROWN

3700

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1½ years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harold Middle A. Last Dorsey				4. DATE OF DEATH Month March Day 25th Year 19 59			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 24th, 1904	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 25 Hours 19 Min. 59		IF UNDER 24 HRS. Months 54 Days 25 Hours 19 Min. 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Isiah Dorsey				14. MOTHER'S MAIDEN NAME Sarah Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217-05-5551H		17. INFORMANT Address Deer's Head State Hospital Records, Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningioma 223X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 223X DUE TO (c) 223X							INTERVAL BETWEEN ONSET AND DEATH 2 ½ yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept. 25, 1957 , to March 25, 1959 , that I last saw the deceased alive on March 25, 1959 , and that death occurred at 6:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 3/25/59							
ACTUAL SIGNATURE M. Juerman				M.D. Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/59		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Alington S. Phillips 1808-10 N. Monroe St.				24a. REC'D BY REGISTRAR MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3747

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First ANNA Middle SPEARY Last EMRICH				4. DATE OF DEATH Month 3 Day 11 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1881	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Speary				14. MOTHER'S MAIDEN NAME Eichelty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Wm. S. Enrich, Annapolis, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Atherosclerotic Cardiovascular Renal Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Pneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3/9 19 59 , to 3/11 19 59 , that I last saw the deceased alive on 3/11 19 59 , and that death occurred at 1:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Nanticoke, Md. 3/12/59							
ACTUAL SIGNATURE Richard H. Saunders M.D. Nanticoke, Md.				DATE SIGNED 3/12/59			
PHYSICIAN'S NAME (Type) Dr. Richard H. Saunders, Nanticoke, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/13/59		22c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery		22d. LOCATION (City, town, or county) (State) Hebron, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co., Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE MAR 17 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Norman T. Baker

U.S. GOVERNMENT PRINTING OFFICE: 1967

• **Figure 5**

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• 112 •

• *Journal of the American Medical Association*

3701

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 110 Glenn Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NETTIE Middle SARAH Last FIELDS		4. DATE OF DEATH Month MARCH Day 30th Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 24, 1886
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 2 Days 8 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee (Shirt Factory)		10b. KIND OF BUSINESS OR INDUSTRY Wicomico Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Daniel A. Hitchens		14. MOTHER'S MAIDEN NAME Mahala C. Maddox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Mr Vernon E. Fields (Son) Address 110 Glenn Rd. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (d).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C.V. Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/20 , 19 59 , to 3/30 , 19 59 , that I last saw the deceased alive on 3/30 , 19 59 , and that death occurred at 3:50A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Medical Center Salisbury, Maryland DATE SIGNED April 1-1959 ACTUAL SIGNATURE Wm B. Smith M.D. Medical Center Salisbury, Maryland PHYSICIAN'S NAME (Type) Dr. William B. Smith Medical Center Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 2, 1959	22c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery	22d. LOCATION (City, town, or county) (State) R.D.# Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE APR 2 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Himes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3701

February

February

1700

1700

January 29, 1944

Albion Co. New York

Albion Co. New York

Albion Co. New York

Albion Co. New York

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Albion Co. New York

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-107. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03698

Item 3702 m G241, 4/15/59 fcy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>12</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		d. STREET ADDRESS <u>30 Keene Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth</u>		4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/20/1931</u>
9. AGE (In years last birthday) <u>28</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Buckingham, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Smith Buckingham, Va.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mattie Holland</u>		Address <u>Buckingham, Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Bullet wound of stomach, liver, left lung and left intercostal artery</u> (a), stating the underlying cause lost. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot through upper abdomen during a quarrel.</u>	
20c. TIME OF INJURY Month, Day, Year <u>12:20 P.M. 3-27-59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Lunch room.</u>		20f. (City or town) (County) (State) <u>Salisbury Wicomico Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-28-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-30-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Ch.</u>		22d. LOCATION (City, town, or county) (State) <u>Buckingham, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton Stewart, Salisbury Md.</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR DATE <u>APR 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

STATE OF
MICHIGAN

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH
CLASS

DECEASED

SEX

DATE OF BIRTH

PLACE OF BIRTH

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DETAILED DESCRIPTION OF DISEASE

DETAILED DESCRIPTION OF INJURY

DETAILED DESCRIPTION OF TOXIC SUBSTANCE

DETAILED DESCRIPTION OF OTHER FACTORS

DETAILED DESCRIPTION OF POST-MORTEM FINDINGS

DETAILED DESCRIPTION OF LABORATORY TESTS

DETAILED DESCRIPTION OF OTHER TESTS

DETAILED DESCRIPTION OF OTHER FACTORS

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3703

CERTIFICATE OF DEATH

Reg. Dist. No.

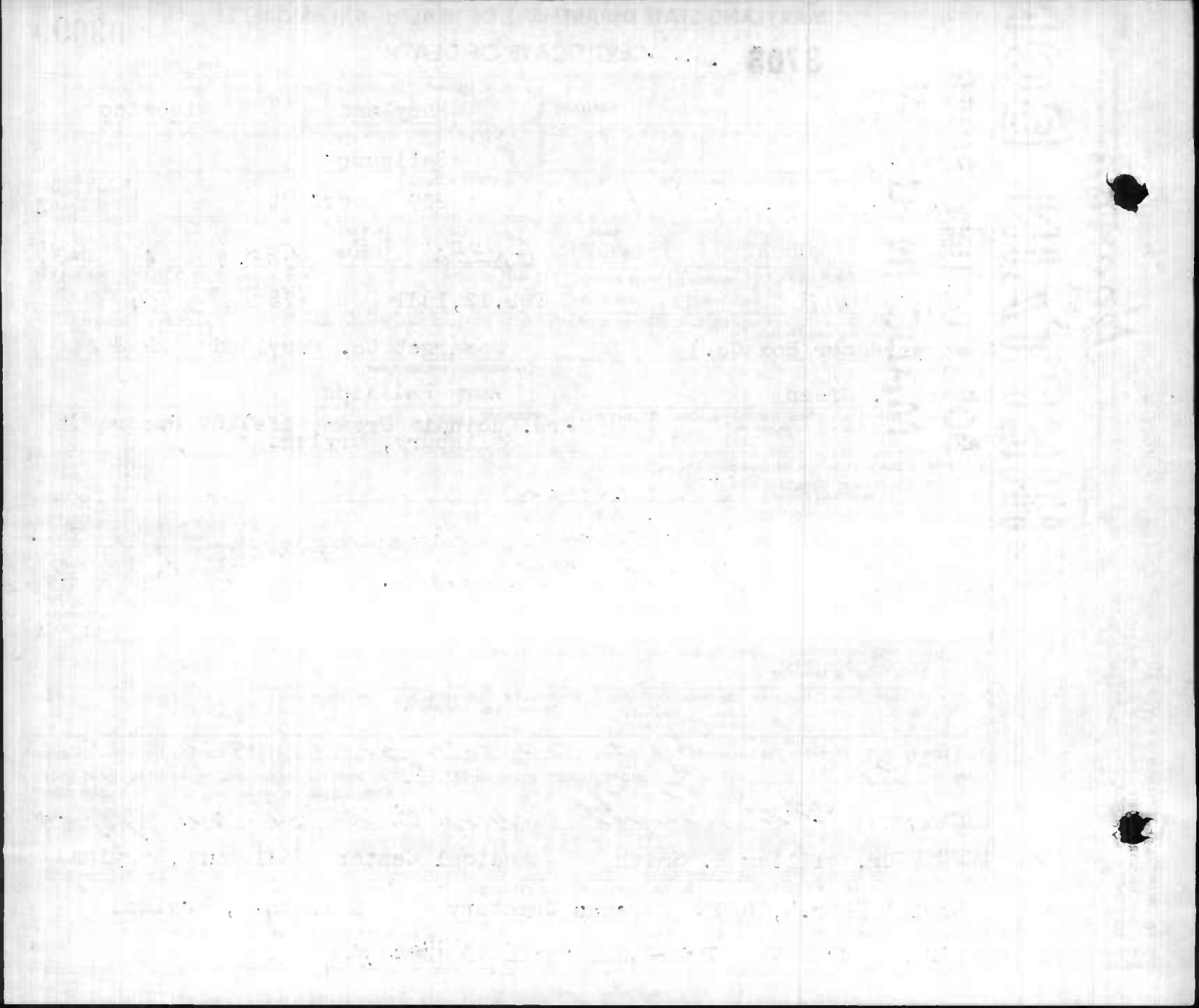
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>12</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>209 Record St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>THOMAS</u> Last <u>GREEN</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>19</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer (Paper Box Co.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Somerset Co. Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Robert T. Green</u>		14. MOTHER'S MAIDEN NAME <u>Mary Phillips</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT Mrs. Lucindia Green (Wife) 209 Record St Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> DUE TO (b) <u>Hyperpyrexia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) <u>Cerebral Vascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>96 hrs</u> <u>72 hrs</u> <u>5 days</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-22, 1959</u> to <u>3-1, 1959</u> , that I lost saw the deceased alive on <u>3-1, 1959</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. William B. Smith</u>		M.D. <u>Med Center Shyml</u> <u>3/1/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. William B. Smith</u>		ADDRESS (Street, city or town, state) <u>Medical Center Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 4, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>MAR 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knead</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58



1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3704

CERTIFICATE OF DEATH

03700

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Aline First Allie Middle Carter Last Hales		4. DATE OF DEATH March Day 2 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 14, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY Shirt Factory	
11. BIRTHPLACE (State or foreign country) Snow Hill, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levin Carter		14. MOTHER'S MAIDEN NAME Hennie Dickerson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-10-4262	
17. INFORMANT Hospital Records, Salisbury, Md.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old cerebral thrombosis		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

21. I certify that I attended the deceased from **February 23 19 59**, to **March 2**, 19 **59**, that I last saw the deceased alive on **March 2**, 19 **59**, and that death occurred at **11:50 P.M.** from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **Deer's Head State Hospital** DATE SIGNED **3/3/59**

ACTUAL SIGNATURE **L. V. Maldve, M. D.** M.D. **Salisbury, Maryland**

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial March 9/59	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Whitcomb Cemetery	22d. LOCATION (City, town, or county) (State) Snow Hill Md
23. FUNERAL DIRECTOR'S SIGNATURE Walter Gummis		24a. REC'D BY REGISTRAR DAMAR 5 '59	
ADDRESS Snow Hill, Md		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03701

3705

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henrietta Middle Handy Last Handy		4. DATE OF DEATH Month March Day 16 Year 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/1879
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Caleb Allen		14. MOTHER'S MAIDEN NAME Amanda Allen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca. of tongue with metastasis to pharynx and neck DUE TO (c) ? INTERVAL BETWEEN ONSET AND DEATH 4-5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 12 , 19 59 , to March 16 , 19 59 , that I last saw the deceased alive on March 16 , 19 59 , and that death occurred at 12:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 3/16/59 ACTUAL SIGNATURE V. Juerman M.D. Deer's Head State Hospital PHYSICIAN'S NAME (Type) V. Juerman, M. D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/59	
22c. NAME OF CEMETERY OR CREMATORY Chesterfield Cem.		22d. LOCATION (City, town, or county) (State) Centerville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Corbitt, Pastor		24a. REC'D BY REGISTRAR DATE MAR 18 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

5706

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15 1900		New York City	
Occupation		Cause of Death		Date of Death		Place of Death		Time of Death	
Teacher		Heart Disease		Jan 20 1945		Home		10:30 AM	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
J. Doe		A. Smith		B. Jones		C. Brown		D. White	
Address		City		State		County		District	
123 Main St		Baltimore		Maryland		Baltimore		1st	

Witness

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

3706

03702

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. STREET ADDRESS 217 N. Park Dr.			
3. NAME OF DECEASED (Type or print) First GLEN Middle TURPIN Last HASTINGS				4. DATE OF DEATH Month March Day 20 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1893	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Contractor		10b. KIND OF BUSINESS OR INDUSTRY Constuction		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gordon Hastings				14. MOTHER'S MAIDEN NAME Clara Turpin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 215-26-5387		17. INFORMANT Mrs. Kathaleen P. Hastings		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lympho sarcoma, neoplastic DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Days Months							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month 3	Day 19	Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Salisbury	(County) Wicomico
21. I certify that I attended the deceased from 3-19 19 59 , to 3-20 19 59 , that I last saw the deceased alive on 3-20 19 59 , and that death occurred at 3:20 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 407 Camden Ave. Salisbury, Maryland DATE SIGNED 3-20-59							
ACTUAL SIGNATURE Earl L. Royer				M.D. Earl L. Royer, M.D.			
PHYSICIAN'S NAME (Type) Earl L. Royer, M.D.				407 Camden Ave. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/ 22/1959		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co., Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE MAR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

Page First of

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN. 10, 1973		HOSPITAL		NATURAL	
AGE		SEX		RACE	
68		M		W	
DATE OF BIRTH		PLACE OF BIRTH		COUNTRY OF BIRTH	
JAN. 10, 1905		BALTIMORE		U.S.A.	
EDUCATION		OCCUPATION		RELIGION	
HIGH SCHOOL		RETIRED		METHODIST	
PREVIOUS ILLNESS		CAUSE OF DEATH		IMMEDIATE CAUSE	
HYPERTENSION		CORONARY THROMBOSIS		HEART FAILURE	
DATE OF ONSET		DATE OF DEATH		DATE OF EXAMINATION	
JAN. 10, 1973		JAN. 10, 1973		JAN. 10, 1973	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN. 10, 1973		JAN. 10, 1973		JAN. 10, 1973	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MD

3707

Items 13, 14 Film G240 4-3-59 et

03703

Reg. Dist. No.

3707

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville 17X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle - Last Hawkins		4. DATE OF DEATH Month March Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22/1877
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Deer's Head State Hosp. Records, Salisbury, Md.	
17. INFORMANT Deer's Head State Hosp. Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac decompensation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) cerebral cerebro-spinal lues; bilateral amaurosis 026X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 18, 19 50 , to March 20, 19 59 , that I last saw the deceased alive on March 20, 19 59 , and that death occurred at 3:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 3/20/59 ACTUAL SIGNATURE G. Kosmahly M.D. Salisbury, Maryland PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 3-25-59	22c. NAME OF CEMETERY OR CREMATORY U of Md. Med. School	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR MAR 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. K...

CERTIFICATE OF DEATH

1957

DECEASED

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIED		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	

3708

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MITCHELL Middle EMORY Last HOPKINS		4. DATE OF DEATH Month MARCH Day 25th Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 4 Days 8 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman-Employee Webb Canning Factory		10b. KIND OF BUSINESS OR INDUSTRY R.D.# Salisbury, Md	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John M. Hopkins		14. MOTHER'S MAIDEN NAME Margaret Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. INFORMANT Mrs. Helen Hopkins (Wife) R.D.# Green Hill Quantico, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Branch Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 30 Burns Rt Arm + Leg			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month 19 Day 15 Year 19 59 Hour a. m. p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/15 , 19 59 to 25 March , 19 59 that I last saw the deceased alive on 25 March , 19 59 , and that death occurred at 6:25 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard H. Saunders		ADDRESS (Street, city or town, state) Nanticoke Md DATE SIGNED March 27 / 59	
PHYSICIAN'S NAME (Type) Dr. Richard H. Saunders		Nanticoke, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 28, 1959	22c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery (Old Part)	22d. LOCATION (City, town, or county) (State) Mardela, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR MAR 31 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03705

Reg. Dist. No.

3709

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b 2 yr 4½ mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air 12X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS County Alms House	
3. NAME OF DECEASED (Type or print) First Noah Middle Pearson Last Jackson		4. DATE OF DEATH Month March Day 19th Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1897
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Jackson		14. MOTHER'S MAIDEN NAME Alice McMillan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk. except for National Guard		16. SOCIAL SECURITY NO. Deer's Head State Hospital Records, Salisbury, Md.	
17. INFORMANT Deer's Head State Hospital Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Residual left monoplegia and dysarthria due to old cerebral thrombosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 5, 1956 , to March 19, 1959 , that I last saw the deceased alive on March 19, 1959 , and that death occurred at 2:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Kosmahly		ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 3/20/59	
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation Mar. 24, 1959	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Greenmount	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc. 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE MAR 26 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• **Prevalence** – the proportion of the population with a disease at a particular point in time

3710

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Accomac</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>13 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Peninsula General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Ann</u> First Middle Last <u>Jester</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1868</u>
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Carpenter</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Cherrix</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT Address <u>Hallie Pettit- New Church, Virginia</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/18</u> , 19 <u>59</u> , to <u>3/31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/31</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis Jr.</u> M.D.		DATE SIGNED <u>3-31-59</u>	
PHYSICIAN'S NAME (Type) <u>W. R. Ellis Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 13, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenbackville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Greenbackville, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Salyer</u> ADDRESS <u>Chincoteague, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 6 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL BANK OF INDIA

1950

THE CENTRAL BANK OF INDIA
RESERVE BANK OF INDIA
GOVERNMENT OF INDIA
MINISTRY OF FINANCE
NEW DELHI

1. The Central Bank of India, established on 1st April 1935, is the apex institution in the financial system of India. It is a public sector enterprise, owned by the Government of India. The Bank's primary objective is to issue currency and to regulate the money supply in the country. It also acts as a banker to the Government and to other banks.

2. The Reserve Bank of India, established on 1st April 1935, is the apex institution in the financial system of India. It is a public sector enterprise, owned by the Government of India. The Bank's primary objective is to issue currency and to regulate the money supply in the country. It also acts as a banker to the Government and to other banks.

3. The Government of India, established on 1st April 1935, is the apex institution in the financial system of India. It is a public sector enterprise, owned by the Government of India. The Bank's primary objective is to issue currency and to regulate the money supply in the country. It also acts as a banker to the Government and to other banks.

4. The Ministry of Finance, established on 1st April 1935, is the apex institution in the financial system of India. It is a public sector enterprise, owned by the Government of India. The Bank's primary objective is to issue currency and to regulate the money supply in the country. It also acts as a banker to the Government and to other banks.

5. The New Delhi, established on 1st April 1935, is the apex institution in the financial system of India. It is a public sector enterprise, owned by the Government of India. The Bank's primary objective is to issue currency and to regulate the money supply in the country. It also acts as a banker to the Government and to other banks.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3711

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03707

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 15 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At home		d. STREET ADDRESS Raynor Farm	
3. NAME OF DECEASED (Type or print) William J Jones		4. DATE OF DEATH 3-12-1959	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1900
9. AGE (in years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Westover, Md.		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME Edward Hall		14. MOTHER'S MAIDEN NAME Sarah Jones Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-01-4744	
17. INFORMANT Sheriff of Wicomico County		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 48 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		DATE SIGNED 3-17-59	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-19-59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town or county) (State) Salisbury	
23. FUNERAL DIRECTOR'S SIGNATURE Beckwith		24a. REC'D BY REGISTRAR DATE MAR 24 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO DEPUTY, MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3712

CERTIFICATE OF DEATH

03708

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>None</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springhill Sanitarium</u>				d. STREET ADDRESS <u>306 S. Clermont Dy.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Earle</u> Last <u>Loreman</u>				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1959</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12, 1880</u>		9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John P. Tawes</u>				14. MOTHER'S MAIDEN NAME <u>Mary Susan White</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>None</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>H. L. Loreman Jr. Salisbury, Maryland</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>794x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infection - Bed fasten</u> DUE TO (c) <u>General Debility</u>								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour _____ a. m. _____ p. m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>Dec. 1959</u> , to <u>3/19, 1959</u> , that I last saw the deceased alive on <u>3/19, 1959</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>W. B. Smith</u> M.D.					ADDRESS (Street, city or town, state) <u>Med. Center, Salisbury, Md.</u>					DATE SIGNED <u>3/19/59</u>
PHYSICIAN'S NAME (Type) <u>Dr. William Smith. Medical Center, Salisbury, Md.</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>3/21/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunny Ridge Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Crisfield, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u>					ADDRESS <u>Norman T. Baker</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Birth		Date of Death	
Place of Birth		Place of Death	
Sex		Race	
Marital Status		Cause of Death	
Occupation		Duration of Illness	
Signature of Physician		Signature of Registrar	
Date of Certificate		Date of Registration	

CERTIFICATE OF DEATH

Reg. Dist. No.

03709

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #2 Eden		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #2 Eden	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Lida Middle Mae Last Malone		4. DATE OF DEATH Month Mar. Day 20 Year 19 59	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1896
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Delware
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George William Moore	
14. MOTHER'S MAIDEN NAME Julia Ann Newton		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Frank Malone, Route #2, Eden, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 1958 to March 20, 1959 , that I last saw the deceased alive on March 20, 1959 , and that death occurred at 10 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William D Gray		DATE SIGNED 3/23/59	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, or other disposal (Specify) burial	22b. DATE THEREOF 3/25/59	22c. NAME OF CEMETERY OR CREMATORY Allen Cemetery	22d. LOCATION (City, town, or county) (State) Allen Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James L. Lerman		ADDRESS Princess Anne, Md	24a. REC'D BY REGISTRAR MAR 30 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN DOE</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>12/15/1925</u></p>		<p>4. Place of birth: <u>NEW YORK, N.Y.</u></p>	
<p>5. Date of death: <u>10/10/1985</u></p>		<p>6. Place of death: <u>NEW YORK, N.Y.</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>10/15/1985</u></p>		<p>12. Place of registration: <u>NEW YORK, N.Y.</u></p>	



UNIVERSITY OF CALIFORNIA - BAYVIEW
 10/10/1985
 NEW YORK, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 See: Birth Cert. et
3713
CERTIFICATE OF DEATH

03710

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Quantico</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. J. H.</i>		d. STREET ADDRESS <i>Box 37</i>	
3. NAME OF DECEASED (Type or print) First <i>Tommy</i> Middle <i>Mills</i> Last <i>Mills</i>		4. DATE OF DEATH Month <i>MARCH</i> Day <i>4th</i> Year <i>1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 25, 1958</i>
9. AGE (In years lost birthday) yrs. <i>3</i>		10. IF UNDER 1 YEAR Months <i>3</i> Days <i>3</i> Hours <i>3</i> Min. <i>3</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Salisbury md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joshua Mitchell</i>		14. MOTHER'S MAIDEN NAME <i>Lucille Mills</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>informant</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>493X</i> DUE TO <i>Pneumonia</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <i>(b) DUE TO</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>(c) DUE TO</i> <i>1) Congenital Heart Disease 2) Intracranial Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/11</i> , 19 <i>59</i> , to <i>3/4</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>3/4</i> , 19 <i>59</i> , and that death occurred at <i>6 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur C. Kells</i> M.D.		ADDRESS (Street, city or town, state) <i>Medical Center, Salisbury</i>	
DATE <i>3/4/59</i>		DATE SIGNED <i>3/4/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-5-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Calvary Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Barker M. West</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>MAR 10 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hanna</i>	

2082151XVI

2



3749

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bivalve</u>				c. LENGTH OF STAY IN 1b <u>One day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Waterview, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Westley Moore</u>				4. DATE OF DEATH Month Day Year <u>March 23 19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/1881</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oysterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Nicholas Moore</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-36-5302</u>		17. INFORMANT <u>Eva Moore</u>		Address <u>Waterview, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>15 July, 1947, to 23 March, 1959</u> , that I last saw the deceased alive on <u>23 March, 1959</u> , and that death occurred at <u>9:55 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Richard H. Saunders</u>		M.D. <u>Nanticoke, Maryland</u>		<u>3/24/59</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders, M.D. Nanticoke, Md.</u>		<u>3/24/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Turner's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nanticoke, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Messick, Funeral, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03712

3714

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

82

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 12 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen Gen Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 325 Penn St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HERMAN Middle MERRILL Last MUMFORD		4. DATE OF DEATH Month MARCH Day 8 Year th 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1915
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 4 Days 3	IF UNDER 24 HRS. Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-Roofer (Sal. Roofing Co.)		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Virgil M. Mumford		14. MOTHER'S MAIDEN NAME Cornelia Parker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11	
17. INFORMANT Mrs. Alfrencia Mumford (Wife)		18. ADDRESS 325 Penn St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of cervical spine 830X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 830X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Car jacked up for repairs and fell on deceased.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car jacked up for repairs and fell on deceased.	
20c. TIME OF INJURY Month, Day, Year 10:50 A.M. 3-8-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard at home		20f. (City or town) Salisbury (County) Wicomico (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 11, 1959	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) Walston Md. (State) D. # Salisbury, Md.)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR MAR 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kiana	

STATE OF NEW YORK
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		JAN 15 1900		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM	
100 N. 10th St.		Carpenter		Diphtheria		Natural		None		None	
FATHER'S NAME		MOTHER'S NAME		BIRTH DATE		BIRTH PLACE		EDUCATION		RELIGION	
JAMES J. JONES		MARY J. JONES		JAN 1 1855		NEW YORK		Common School		Roman Catholic	
PREVIOUS ILLNESS		TREATMENT		PHYSICIAN		HOSPITAL		BURIAL PLACE		INTERMENT	
None		None		Dr. J. J. Jones		None		Catholic Cemetery		Buried	
SIGNATURE OF EXAMINER		CERTIFICATE NO.		DATE		PLACE		COUNTY		STATE	
J. J. Jones		100		JAN 15 1900		NEW YORK		NEW YORK		NEW YORK	

3715

CERTIFICATE OF DEATH

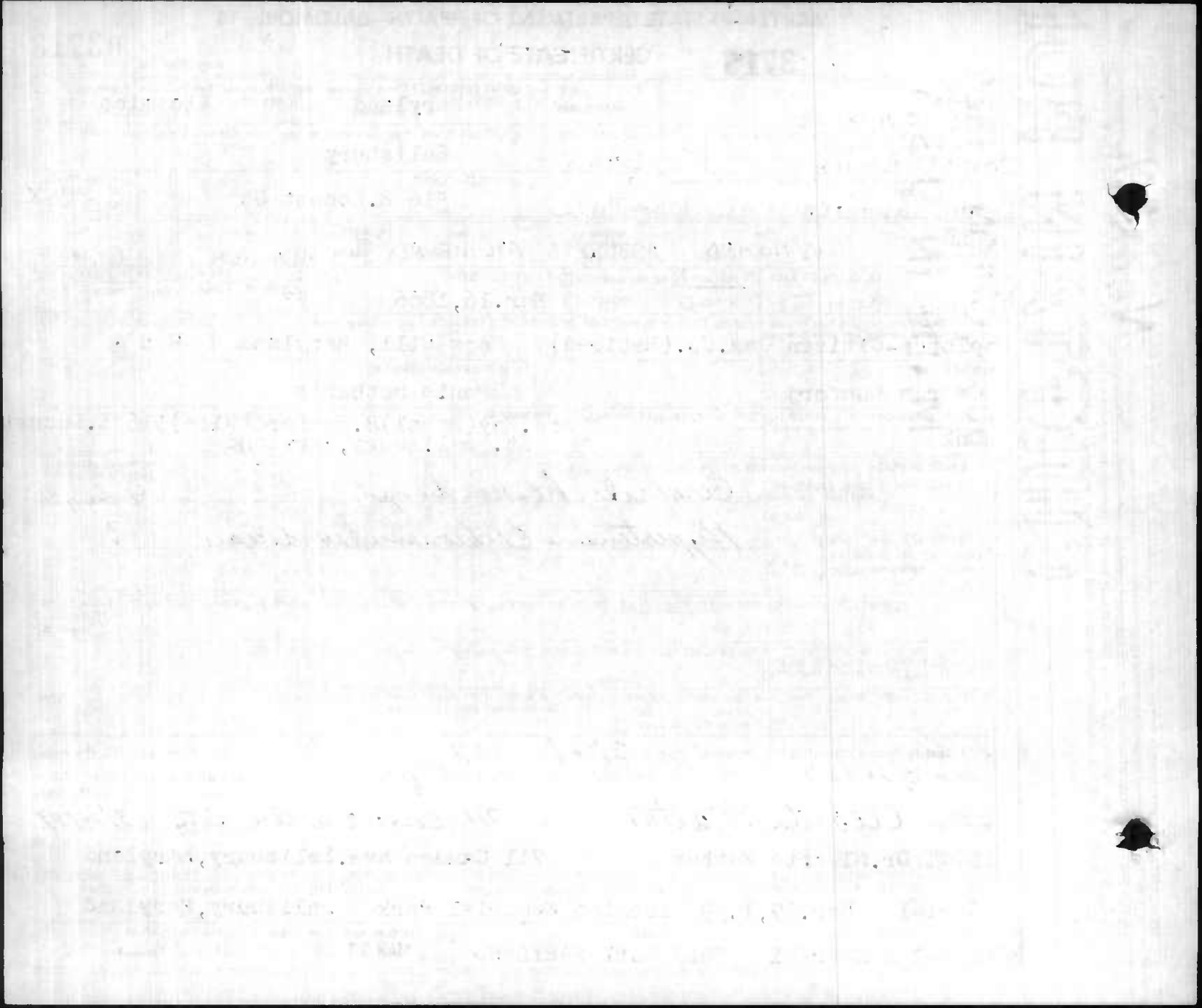
Reg. Dist. No.

03713

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>10 DAYS</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>				d. STREET ADDRESS <u>1 516 E. Locust St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLARD</u> Middle <u>ASBURY</u> Last <u>MUMFORD</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 16, 1886</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee-Citizen Gas. Co. (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Snow Hill, Maryland</u>			
13. FATHER'S NAME <u>George Mumford</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Bethards</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>				16. SOCIAL SECURITY NO. <u>INFORMANT</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>3/16/59</u> , 1959, to <u>3/26/59</u> , 1959, that I last saw the deceased alive on <u>3/26/59</u> , 1959, and that death occurred at <u>7:05</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alberta Mattax</u>				ADDRESS (Street, city or town, state) <u>711 Camden Ave., City 3/26/59</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Alberta Mattax</u>				711 Camden Ave. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 29, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>			
24a. REC'D BY REGISTRAR DATE <u>MAR 31 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3716

CERTIFICATE OF DEATH

03714

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY Sussex			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 24 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS State Highway			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle THOMAS Last O'NEIL				4. DATE OF DEATH Month March Day 26 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY RR Conductor		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Henry O'Neil				14. MOTHER'S MAIDEN NAME Laura Whaley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Doris J. Savage, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degenerative Heart Disease 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/2, 19 59 to 3/26, 19 59 , that I last saw the deceased alive on 3/26, 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md DATE SIGNED 3/28/59							
ACTUAL SIGNATURE Wilbur R. Ellis, Jr. M.D.				DATE SIGNED 3/28/59			
PHYSICIAN'S NAME (Type) Wilbur R. Ellis, Jr.				Medical Center, Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/28/1959		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co., Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

3118

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>NAME OF DECEASED HENRY O. HILL</p>		<p>AGE 65</p>		<p>SEX Male</p>		<p>RACE White</p>		<p>DATE OF DEATH June 12, 1944</p>		<p>TIME OF DEATH 10:30 A.M.</p>	
<p>PLACE OF DEATH Baltimore, Maryland</p>		<p>RESIDENCE Baltimore, Maryland</p>		<p>BIRTHPLACE Baltimore, Maryland</p>		<p>DATE OF BIRTH June 12, 1879</p>		<p>TIME OF BIRTH 10:30 A.M.</p>		<p>PLACE OF BIRTH Baltimore, Maryland</p>	
<p>CAUSE OF DEATH Heart Failure</p>		<p>IMMEDIATE CAUSE Coronary Thrombosis</p>		<p>UNDERLYING CAUSE Atherosclerosis</p>		<p>PREVIOUS ILLNESS None</p>		<p>PREVIOUS SURGERY None</p>		<p>PREVIOUS TRAUMA None</p>	
<p>REPORTED BY Dr. J. H. Hill</p>		<p>REPORTED BY Dr. J. H. Hill</p>		<p>REPORTED BY Dr. J. H. Hill</p>		<p>REPORTED BY Dr. J. H. Hill</p>		<p>REPORTED BY Dr. J. H. Hill</p>		<p>REPORTED BY Dr. J. H. Hill</p>	
<p>SIGNATURE OF REPORTER J. H. Hill</p>		<p>SIGNATURE OF REPORTER J. H. Hill</p>		<p>SIGNATURE OF REPORTER J. H. Hill</p>		<p>SIGNATURE OF REPORTER J. H. Hill</p>		<p>SIGNATURE OF REPORTER J. H. Hill</p>		<p>SIGNATURE OF REPORTER J. H. Hill</p>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3717

CERTIFICATE OF DEATH

Reg. Dist. No.

03715

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OLON</u> Middle <u>JACOB</u> Last <u>Parker</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1898</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stanton Parker</u>		14. MOTHER'S MAIDEN NAME <u>Priscella Hamblin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>217-36-0838</u>	
INFORMANT <u>Mrs. O.J. Parker, Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Heart Disease</u> <u>420.1</u> DUE TO <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary Atherosclerosis</u> (c) <u>Coronary Atherosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sign</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1956</u> to <u>March 29, 1959</u> that I last saw the deceased alive on <u>March 28, 1959</u> and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Rd. Salisbury, Md.</u> DATE SIGNED <u>March 29, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Dr. David J. Gilmore Medical Center, Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/31/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman T. Baker</u>		ADDRESS <u>The Hill & Johnson Co. Salisbury, Maryland</u>	
24a. REC'D BY REGISTRAR <u>APR 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3718

CERTIFICATE OF DEATH

Reg. Dist. No.

03716

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Sanitarium Inc.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSA Middle MAY Last PARKER		4. DATE OF DEATH Month MARCH Day 21st Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1867
9. AGE (In years lost birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Wico.Co.Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Mitchell Collins		14. MOTHER'S MAIDEN NAME Martha Washington Mills	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Mr. Albert Parker (Son) R.D.# 4 Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1948 to 3-21 , 19 59 that I last saw the deceased alive on 3-5 , 19 59 , and that death occurred at 9:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Main St. Salisbury, Maryland DATE SIGNED March 23/1959			
ACTUAL SIGNATURE Philip A. Insley M.D.		PHYSICIAN'S NAME (Type) Dr. Philip A. Insley	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 24, 1959	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park
22d. LOCATION (City, town, or county) Salisbury, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR MAR 24 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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3719

CERTIFICATE OF DEATH

03717

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS ----			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Parks</u>				4. DATE OF DEATH Month Day Year <u>March 20 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20, 1959</u>	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min <u>45</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>SHERDON PARKS</u>				14. MOTHER'S MAIDEN NAME <u>WILMETTA JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Address <u>SHERDON PARKS. PRINCESS ANNE, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity.</u> 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prenatal rupture of umbilical cord.</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/20</u> , 19 <u>59</u> , to <u>3/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/20</u> , 19 <u>59</u> , and that death occurred at <u>11:00</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Stecher W. Smith</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>JOHN WESLEY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCESS ANNE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM H. JAMES JR. PRINCESS ANNE, MD</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 30 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3720

CERTIFICATE OF DEATH

03718

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium, Inc.		d. STREET ADDRESS Rt. 1	
3. NAME OF DECEASED (Type or print) First Horace Middle G. Last Payne		4. DATE OF DEATH Month Mar. Day 4 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1881
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 7 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Business		10b. KIND OF BUSINESS OR INDUSTRY Farming Real Estate	
11. BIRTHPLACE (State or foreign country) Pocomoke City		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William H. Payne		14. MOTHER'S MAIDEN NAME Sarah E. Hancock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Yellie B. Payne		Address Snow Hill, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unknown			INTERVAL BETWEEN ONSET AND DEATH 18 months ago
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1/10 , 19 59 , to Mar. 4 , 19 59 , that I lost saw the deceased olive on 3/4 , 19 59 , and that death occurred at 9:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Medical Center, Salisbury, Md. DATE SIGNED			
ACTUAL SIGNATURE David J. Gilmore		M.D. Medical Center, Salisbury, Md.	
PHYSICIAN'S NAME (Type) Dr. David J. Gilmore			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial March 7/59		22b. NAME OF CEMETERY OR CREMATORY White Cemetery	
22c. LOCATION (City, town, or county) (State) Snow Hill, Md			
23. FUNERAL DIRECTOR'S SIGNATURE Clay & Burns		ADDRESS Snow Hill, Md	
24a. REC'D BY REGISTRAR DATE MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03719

3721

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 807 E. William St		d. STREET ADDRESS 1 807 E. William St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RICHARD Middle F. Last PERRY		4. DATE OF DEATH Month MARCH Day 28th Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1864
9. AGE (In years last birthday) 94		10. IF UNDER 1 YEAR Months 6 Days 10 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tin Smith		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Richard Perry		14. MOTHER'S MAIDEN NAME Sarah Hobbs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. Mr. Richard A. Perry (Son) 201 New York Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cerebral embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intermittent Cardiovascular disease 10 yrs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sanctity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1951 to Mar 28, 1959 that I last saw the deceased alive on Mar 28, 1959, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Alberta Mattax M.D. 711 Camden Ave March 30 1959 PHYSICIAN'S NAME (Type) Dr. Alberta Mattax 711 Camden Ave. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 31, 1959	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR DATE MAR 31 '59	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur S. Knap	

3751

Location

Address

Box 11111111

Richard

E.

Henry

Harold

610

610

White

Construction

Building

Building

Building

Building

Mr. Richard E. Henry
Building

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ROLDAY & COMPANY, BALTIMORE, MARYLAND

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03720

3722

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> <u>23X-2</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			d. STREET ADDRESS <u>Bay Ridge Farm</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nancy KATHRYN Purnell</u>			4. DATE OF DEATH Month Day Year <u>3-26-1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 28 1942</u>		9. AGE (In years last birthday) <u>17</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pupil</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HIGH SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			13. FATHER'S NAME <u>WILLIAM M. Purnell</u>		
14. MOTHER'S MAIDEN NAME <u>KATHRYN ZULLEN</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>WILLIAM M. Purnell</u> <u>Ocean City, Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured cervical spine</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in car that ran off road and turned over.</u>			
20c. TIME OF INJURY Month, Day, Year <u>17</u> <u>4</u> <u>3-26-59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) <u>Berlin</u>	20g. (County) <u>Worcester</u>	20h. (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-28-59</u>		
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>			22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		
22b. DATE THEREOF <u>3/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS</u>		22d. LOCATION (City, town, or county) (State) <u>BISHOPVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burbage</u>		ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 1 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE OF TEXAS

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CITY

COUNTY

STATE

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

POLITICAL PARTY

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CITY

COUNTY

STATE

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

POLITICAL PARTY

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CITY

COUNTY

STATE

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

POLITICAL PARTY

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CITY

COUNTY

STATE

CAUSE OF DEATH

MANNER OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3723

CERTIFICATE OF DEATH

03721

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jacob Middle Cannon Last Savage				4. DATE OF DEATH Month March Day 3 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 2, 1878	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 3 Days 19 Hours 59 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Delmar				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William T. Savage				14. MOTHER'S MAIDEN NAME Nancy E. Gunby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, generalized DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of prostate DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from February 17, 19 59 , to March 3, 19 59 , that I last saw the deceased alive on March 3, 19 59 , and that death occurred at 6:20A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Kosmahly				ADDRESS (Street, city or town, state) Deer's Head State Hospital		DATE SIGNED 3/3/59	
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/4/59		22c. NAME OF CEMETERY OR CREMATORY New Hope Cem.		22d. LOCATION (City, town, or county) (State) WILLARDS MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Watson & Guy				ADDRESS Frederick		24a. REC'D BY REGISTRAR DATE MAR 17 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. K...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3724

CERTIFICATE OF DEATH

Reg. Dist. No.

03722

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seaford</u> <u>46X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Schaefer</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 13, 1959</u>
9. AGE (In years last birthday) yrs. <u>6</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u> Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wesley Schaefer</u>		14. MOTHER'S MAIDEN NAME <u>Joyce Richardson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Mr. Wesley Schaefer, Seaford, Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Alelectasis</u> DUE TO (b) <u>Prematurity (Birth wt. 1165 gms)</u> DUE TO (c) <u>6 hrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/13</u> , 19 <u>59</u> , to <u>3/14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/14</u> , 19 <u>59</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>Medical Center</u>			
ACTUAL SIGNATURE <u>Alfred C. Kolls</u> M.D.		PHYSICIAN'S NAME (Type) <u>Dr. Alfred C. Kolls</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 17 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

Norman T. Baker 2082312XV1

CERTIFICATE OF DEATH

Deceased

Married

Age

Sex

Date of Birth

Place of Birth

Occupation

Signature

Witness

Registrar

Signature

Witness

Registrar

Signature

Witness

Registrar

Signature

Witness

Registrar

3725

CERTIFICATE OF DEATH

03723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>238-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>RFD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARLEY J. Selby</u>				4. DATE OF DEATH Month Day Year <u>March 19 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1884</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Sampson Selby</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Holloway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <u>INFORMANT</u>			
17. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>38 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2-23</u> , 19 <u>59</u> , to <u>3-19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>6:57</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Elliott</u> M.D.				DATE SIGNED <u>3-20-59</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>S. O. O. F.</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Thomas</u> ADDRESS <u>Salisbury, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REPORT OF DEATH

1932



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3726

CERTIFICATE OF DEATH

13724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WILCOMICO</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>11 DAYS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL</u> <u>23X-2</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>SILVERMAN</u> Last S. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>(UNK)</u> 1888 9. AGE (In years lost birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			4. DATE OF DEATH <u>MARCH</u> <u>7</u> 19 <u>59</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>UNK</u>		14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>24-32-7374</u>		17. Address <u>Mrs. SHAK Rudolph (Daughter) 37 Over Brook Parkway - Overbrook Hills PA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>Degenerative Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Fibrosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2-24</u> , 19 <u>57</u> to <u>3-7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-7</u> , 19 <u>59</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>3-7-59</u>							
ACTUAL SIGNATURE <u>William R. Ellis, Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>Dr. William R. Ellis Jr. Medical Center - Salisbury Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-8-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Har Nebo Cem. Philadelphia PA.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway Company - Salisbury Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>MAR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

3338

CERTIFICATE OF DEATH

[Faint, illegible text, likely bleed-through from the reverse side of the page]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3727

CERTIFICATE OF DEATH

03725

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen Hosp		e. STREET ADDRESS 314 Ellen Street	
3. NAME OF DECEASED (Type or print) Frank Simmons		4. DATE OF DEATH Month 3 Day 11 Year 19 59	
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/1901
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 240 12 5183	
17. INFORMANT Mrs. Pauline Dickerson, Salisbury, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - hypostatic + bacterial 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left cerebral hemorrhage DUE TO (c) Hypertensive cardiac vascular disease		INTERVAL BETWEEN ONSET AND DEATH 3 days 1 month Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pylorospasm		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/7/59 , 19 59 , to 3/11/59 , that I last saw the deceased alive on 3/10/59 , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 211 Maryland Avenue DATE SIGNED 3/11/59			
ACTUAL SIGNATURE O. J. Burton, M.D.		PHYSICIAN'S NAME (Type) Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/1959	
22c. NAME OF CEMETERY OR CREMATORY Green Acree Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Stewart Funeral Home, Salisbury, Md		ADDRESS	
24a. REC'D BY REGISTRAR MAR 17 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BY APPROVED - MEANS OF THE STATE QUALITY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3750 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03726

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)		c. LENGTH OF STAY IN 1b App: 2wks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# Johnson Road				d. STREET ADDRESS 321 Newton St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="text-align: center;">First Middle Last FULTON KNIGHT SINGLETON</div>				4. DATE OF DEATH <div style="text-align: center;">Month Day Year MARCH 14th 19 59</div>			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1st, 1922		9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR Months 0 Days 13	IF UNDER 24 HRS. Hours 0 Min. 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Lumberman		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Hillsdale N.J.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Edward S. Singleton				14. MOTHER'S MAIDEN NAME Martha Kirkpatrick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W.W.11		17. INFORMANT Mrs. Dora R. Singleton (Wife) 321 Newton St Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning 9773.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Attached to car exhaust					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 3-14 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Wicomico Wicomico Md			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED March 28 /1959			
EXAMINER'S NAME (Type) Dr. Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 30, 1959	22c. NAME OF CEMETERY OR CREMATORY Geo. Washington Mem. Park		22d. LOCATION (City, town, or county) (State) Paramus, New Jersey			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND		24a. REC'D BY REGISTRAR MAR 31 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED John F. Brown		AGE 45		SEX Male		RACE White		DATE OF DEATH April 1, 1918		PLACE OF DEATH Home	
RESIDENCE 1234 Main St., Baltimore, Md.		OCCUPATION Clerk		EDUCATION High School		MARRIAGE Married		CAUSE OF DEATH Pneumonia		MANNER OF DEATH Natural	
BIRTH April 1, 1873		PLACE OF BIRTH Maryland		PARENTS John F. Brown, Sr., Mary F. Brown		SPOUSE Mary F. Brown		CHILDREN None		PREVIOUS ILLNESS None	
SIGNATURE OF DECEASED John F. Brown		SIGNATURE OF WITNESS Mary F. Brown		SIGNATURE OF PHYSICIAN Dr. J. H. Smith		SIGNATURE OF CLERK J. H. Smith		SIGNATURE OF REGISTRAR J. H. Smith		SIGNATURE OF JURY None	
DATE OF REGISTRATION April 1, 1918		PLACE OF REGISTRATION Baltimore, Md.		OFFICE OF REGISTRATION Baltimore, Md.		OFFICE OF HEALTH Baltimore, Md.		OFFICE OF VITALS Baltimore, Md.		OFFICE OF RECORDS Baltimore, Md.	

3729

CERTIFICATE OF DEATH

Reg. Dist. No.

03728

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>6 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>23x-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Jr.</u> Last <u>Smullen</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 15 1888</u>	
9. AGE (In years last birthday) <u>70</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gun Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Samuel R. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lizzie Wuskey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr. James C. Hambley</u>				18. ADDRESS <u>Shaw Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Degenerative Heart Disease</u> (c) <u>Centenarian</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Centenarian</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3-1</u> , 19 <u>59</u> , to <u>3-7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-7</u> , 19 <u>59</u> , and that death occurred at <u>12:00</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Ellis, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>3-8-59</u>			
PHYSICIAN'S NAME (Type) <u>William R. Ellis, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>March 9/59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Shaw Hill, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas F. Harris</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 11 '59</u>			
ADDRESS <u>Shaw Hill, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3730

CERTIFICATE OF DEATH

03729

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton d. STREET ADDRESS R 2, Box 190	
3. NAME OF DECEASED (Type or print) First William Middle Alfred Last Stanley		4. DATE OF DEATH Month March Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1895
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Type of Factory	
11. BIRTHPLACE (State or foreign country) Hurlock, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harison Stanley		14. MOTHER'S MAIDEN NAME Lurenda Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 160-14-2008	
17. INFORMANT Hospital Records, Address Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Recurrent cerebral hemorrhage DUE TO (c) Hypertensive arteriosclerotic cardiovascular disease ?			INTERVAL BETWEEN ONSET AND DEATH 4 days 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 9, 1959 , to March 18, 1959 , that I last saw the deceased alive on March 18, 1959 , and that death occurred at 8:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE V. Juerman		ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 3/18/59	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 21, 1959	22c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery	22d. LOCATION (City, town, or county) (State) Federalburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frempton and Son, ADDRESS Federalburg, Maryland		24a. REC'D BY REGISTRAR MAR 23 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

CERTIFICATE OF DEATH

Albany

1891

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Item 3 Film G239 3-11-59 et

3731

CERTIFICATE OF DEATH

03730

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>29 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Wesley</u> Last <u>Stevens</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/28/1887</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic-Ret.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jesse Stevens</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Carroll</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) [Yes, no, or unknown]				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital Records</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung (right)</u> DUE TO <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1959</u> Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Feb. 2</u> , 19 <u>59</u> , to <u>March 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 3</u> , 19 <u>59</u> , and that death occurred at <u>8:45 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>3/4/59</u>							
ACTUAL SIGNATURE <u>G. Kosmahly</u>				PHYSICIAN'S NAME (Type) <u>G. Kosmahly, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>				ADDRESS <u>East New Market, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				DATE <u>MAR 6 '59</u>		24c. LOCATION (City, town, or county) <u>East New Market, Md.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03731

3732

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 334 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Grant Middle Taylor Last Taylor				4. DATE OF DEATH Month March Day 1 Year 19 59			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1, 1889		9. AGE (In years last birthday) yrs. 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rehobeth, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Taylor				14. MOTHER'S MAIDEN NAME Rose Wilkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) ? INTERVAL BETWEEN ONSET AND DEATH 3 min							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteomyelitis of sacrum							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1 , 19 58 , to March 1 , 19 59 , that I last saw the deceased alive on March 1 , 19 59 , and that death occurred at 8:10 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 3/2/59 ACTUAL SIGNATURE V. Juerman M.D. PHYSICIAN'S NAME (Type) V. Juerman, M. D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3.5.59		22c. NAME OF CEMETERY OR CREMATORY W. L. Med. School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE MAR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3733

Item 1 Film G241 4-6-59 et

CERTIFICATE OF DEATH

03732

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>727 Dennis St. (Boarding House)</u>		d. STREET ADDRESS <u>1 727 Sunset Heights</u>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Taylor</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 10-1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>	
13. FATHER'S NAME <u>John H. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Bessie J. Dale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>Unk</u> <u>Unk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 24, 1959</u> to <u>March 25, 1959</u> , that I last saw the deceased alive on <u>Mar. 24, 1959</u> , and that death occurred at <u>9:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Herbert Sempley</u>		DATE SIGNED <u>Mar 25 1959</u>	
PHYSICIAN'S NAME (Type) <u>G. Herbert Sempley</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF <u>March 28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Taylor State Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Snowhill MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay E. Gimmis</u>		24. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	
ADDRESS <u>Snowhill, MD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. King</u>	

CERTIFICATE OF DEATH

3735

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>	
<p>4. PLACE OF BIRTH</p>		<p>5. DATE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>	
<p>10. SIGNATURE OF PHYSICIAN</p>		<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF NEXT OF KIN</p>		<p>15. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>16. SIGNATURE OF FUNERAL HOME</p>		<p>17. SIGNATURE OF CHURCH</p>		<p>18. SIGNATURE OF CEMETERY</p>	
<p>19. SIGNATURE OF CORONER</p>		<p>20. SIGNATURE OF JURY</p>		<p>21. SIGNATURE OF JUDGE</p>	
<p>22. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>23. SIGNATURE OF SHERIFF</p>		<p>24. SIGNATURE OF CLERK</p>	
<p>25. SIGNATURE OF NOTARY</p>		<p>26. SIGNATURE OF JURY</p>		<p>27. SIGNATURE OF JUDGE</p>	
<p>28. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>29. SIGNATURE OF SHERIFF</p>		<p>30. SIGNATURE OF CLERK</p>	
<p>31. SIGNATURE OF NOTARY</p>		<p>32. SIGNATURE OF JURY</p>		<p>33. SIGNATURE OF JUDGE</p>	
<p>34. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>35. SIGNATURE OF SHERIFF</p>		<p>36. SIGNATURE OF CLERK</p>	
<p>37. SIGNATURE OF NOTARY</p>		<p>38. SIGNATURE OF JURY</p>		<p>39. SIGNATURE OF JUDGE</p>	
<p>40. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>41. SIGNATURE OF SHERIFF</p>		<p>42. SIGNATURE OF CLERK</p>	
<p>43. SIGNATURE OF NOTARY</p>		<p>44. SIGNATURE OF JURY</p>		<p>45. SIGNATURE OF JUDGE</p>	
<p>46. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>47. SIGNATURE OF SHERIFF</p>		<p>48. SIGNATURE OF CLERK</p>	
<p>49. SIGNATURE OF NOTARY</p>		<p>50. SIGNATURE OF JURY</p>		<p>51. SIGNATURE OF JUDGE</p>	
<p>52. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>53. SIGNATURE OF SHERIFF</p>		<p>54. SIGNATURE OF CLERK</p>	
<p>55. SIGNATURE OF NOTARY</p>		<p>56. SIGNATURE OF JURY</p>		<p>57. SIGNATURE OF JUDGE</p>	
<p>58. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>59. SIGNATURE OF SHERIFF</p>		<p>60. SIGNATURE OF CLERK</p>	
<p>61. SIGNATURE OF NOTARY</p>		<p>62. SIGNATURE OF JURY</p>		<p>63. SIGNATURE OF JUDGE</p>	
<p>64. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>65. SIGNATURE OF SHERIFF</p>		<p>66. SIGNATURE OF CLERK</p>	
<p>67. SIGNATURE OF NOTARY</p>		<p>68. SIGNATURE OF JURY</p>		<p>69. SIGNATURE OF JUDGE</p>	
<p>70. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>71. SIGNATURE OF SHERIFF</p>		<p>72. SIGNATURE OF CLERK</p>	
<p>73. SIGNATURE OF NOTARY</p>		<p>74. SIGNATURE OF JURY</p>		<p>75. SIGNATURE OF JUDGE</p>	
<p>76. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>77. SIGNATURE OF SHERIFF</p>		<p>78. SIGNATURE OF CLERK</p>	
<p>79. SIGNATURE OF NOTARY</p>		<p>80. SIGNATURE OF JURY</p>		<p>81. SIGNATURE OF JUDGE</p>	
<p>82. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>83. SIGNATURE OF SHERIFF</p>		<p>84. SIGNATURE OF CLERK</p>	
<p>85. SIGNATURE OF NOTARY</p>		<p>86. SIGNATURE OF JURY</p>		<p>87. SIGNATURE OF JUDGE</p>	
<p>88. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>89. SIGNATURE OF SHERIFF</p>		<p>90. SIGNATURE OF CLERK</p>	
<p>91. SIGNATURE OF NOTARY</p>		<p>92. SIGNATURE OF JURY</p>		<p>93. SIGNATURE OF JUDGE</p>	
<p>94. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>95. SIGNATURE OF SHERIFF</p>		<p>96. SIGNATURE OF CLERK</p>	
<p>97. SIGNATURE OF NOTARY</p>		<p>98. SIGNATURE OF JURY</p>		<p>99. SIGNATURE OF JUDGE</p>	
<p>100. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>101. SIGNATURE OF SHERIFF</p>		<p>102. SIGNATURE OF CLERK</p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03733

3734

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 503 Mitchell St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 503 Mitchell St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCES Middle BARRANCO Last TESTA		4. DATE OF DEATH Month MARCH Day 3rd Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1873
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR 11 Months 24 Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Cefalu Italy
12. CITIZEN OF WHAT COUNTRY? Italy		13. FATHER'S NAME Giovanni(John) Barranco	
14. MOTHER'S MAIDEN NAME Maria Grazia Maghiola		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. Mr. John Testa (Son) 407 Royal St. Salisbury, Maryland		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.0 Cordiac arrest. DUE TO Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/28/58 , 19 58 , to 3/5/59 , 19 59 , that I last saw the deceased alive on 3/2/59 , 19 59 , and that death occurred at 1:48 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Andrew C. Mitchell		M.D. 211 Maryland Ave. Salisbury, Maryland DATE SIGNED March 5 / 1959	
PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell		Maryland Ave. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 5, 1959	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR MAR 6 59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

Age

Sex

Place of Birth

Date

Time

Cause

Place

Signature

Witness

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3735

CERTIFICATE OF DEATH

Reg. Dist. No.

03734

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b App: 1 wk <u>12</u> Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM B. Truckenmiller</u>		4. DATE OF DEATH Month Day Year <u>March 12 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 29, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Highway Dept. Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Allenwood, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William C. Truckenmiller</u>		14. MOTHER'S MAIDEN NAME <u>Martha Bryson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT Mr. George A. Wallet (Son-in-Law) 332 Camden Ave. Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Myocardial Infarction</u> (c) <u>Proteinuric C-V Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 19 58</u> to <u>March 12 19 59</u> , that I lost saw the deceased alive on <u>March 12 19 59</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Gray</u> M.D.		ADDRESS (Street, city or town, state) <u>334 Camden Ave. Salisbury, Maryland</u> DATE SIGNED <u>3/12/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. William D. Gray</u>		<u>334 Camden Ave. Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 16, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Muncy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Muncy, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 16 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

NAME

AGE

DATE OF BIRTH

SEX

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

SIGNATURE

DATE

REGISTRATION

OFFICE

CITY

STATE

COUNTY

TOWNSHIP

SECTION

RANGE

TRIM

QUARTER

ACREAGE

ADDITIONAL INFORMATION

REMARKS

Item 9, Film G240, 3/24/59 fcy
3736
CERTIFICATE OF DEATH

03735

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 6 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Eden		d. STREET ADDRESS Route # 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hosp		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Seymore Middle Wallace Last		4. DATE OF DEATH Month 3 Day 11 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/10/1900
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence Wallace		14. MOTHER'S MAIDEN NAME Ellen Boulson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Mary Wallace, Eden, Md. Route 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis - 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Myocardial Infarction DUE TO (c) Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH 2 days 4 days 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 6, 1959 , to March 11, 1959 , that I last saw the deceased alive on March 10, 1959 , and that death occurred at 1:25 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Herbert Sembly		ADDRESS (Street, city or town, state) 400 E. Church St. Salisbury, Md.	
PHYSICIAN'S NAME (Type) Herbert G. Sembly, MD		DATE SIGNED 3/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/1959	
22c. NAME OF CEMETERY OR CREMATORY Jordan Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Barnwell, South Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.		24. REC'D BY REGISTRAR MAR 17 '59	
25. REGISTRAR'S SIGNATURE Arthur S. Krana			

CERTIFICATE OF DEATH

36

NAME OF DECEASED _____	
SEX _____	
AGE _____	
DATE OF BIRTH _____	
PLACE OF BIRTH _____	
OCCUPATION _____	
CAUSE OF DEATH _____	
PLACE OF DEATH _____	
TIME OF DEATH _____	
SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF REGISTRAR _____	
DATE _____	



3737

CERTIFICATE OF DEATH

03736

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>2 Days</u> x <u>Bivalve</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TEWINSULA General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>L.</u> Last <u>WALTER</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/1896</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor of Assessments of Wic. County</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Bernside Walter</u>		14. MOTHER'S MAIDEN NAME <u>Ella Lemoore Messick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>220-12-0503</u>	
17. INFORMANT <u>Debra Lee Walter</u>		Address <u>Bivalve, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.1 Congestive Heart Failure</u> DUE TO (b) <u>Auricular Fibrillation with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>uncontrolled Rate</u> DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right Pneumonectomy for Carcinoma of Lung</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 3, 1959</u> to <u>March 6, 1959</u> , that I last saw the deceased alive on <u>March 6, 1959</u> , and that death occurred at <u>9:02 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Pine Bluff Road, Salesbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Thomas C. Hill, Jr.</u>		DATE SIGNED <u>March 6, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/8/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bivalve Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bivalve, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. N. Messick</u> ADDRESS <u>Bivalve, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0170

0383

ENGINE CASE OF 2011

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "engine", "case", and "2011" are faintly visible.]



3738

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Shapton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>Maple Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JANE</u> Middle <u>FRANCES</u> Last <u>Warden</u>				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-1903</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>55</u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John MacAlease</u>				14. MOTHER'S MAIDEN NAME <u>Gold Frances Lee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		INFORMANT <u>Robert Warden Shapton</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Acidosis, Dehydration, Coma</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 16, 1959</u> , to <u>March 19, 1959</u> , that I last saw the deceased alive on <u>March 19, 1959</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Paie Bluff Road</u> DATE SIGNED <u>3/20/59</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-23-59</u>		<u>Our Lady of Lourdes</u>		<u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Marvel - Shapton, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

RECEIVED AND FORWARDED TO THE SECRETARY OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3739

CERTIFICATE OF DEATH

03738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		d. STREET ADDRESS Delmar Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUIS Middle RICHARD Last WETZEL		4. DATE OF DEATH Month MARCH Day 16th Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Single	8. DATE OF BIRTH Nov. 29, 1906
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR: Months 52 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-Auto Garage-Body Repair		10b. KIND OF BUSINESS OR INDUSTRY Washington D.C.	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Henry Wetzel		14. MOTHER'S MAIDEN NAME Catherine McCarty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.II		16. SOCIAL SECURITY NO. INFORMANT Rev. Bernhard F. Wetzel (Brother) 3301 Solly Ave. Phila 36, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Failure DUE TO (c) Myocardial Failure			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan , 19 57 , to 3/16 , 19 59 , that I last saw the deceased alive on 3/14 , 19 59 , and that death occurred at 9 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William B. Smith		ADDRESS (Street, city or town, state) M.D. Medical Center Sky Rd. DATE SIGNED Mar. 17/1959	
PHYSICIAN'S NAME (Type) Dr. William B. Smith		Medical Center - Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 18, 1959	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR MAR 19 59		24b. REGISTRAR'S SIGNATURE Charles E. Hume	

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CENTRAL EX-104

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3740

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>CANNON</u> Last <u>White</u>		4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1876</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee of County Court House</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Elihue White</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah Kimmey</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>INFORMANT</u>		Address <u>Miss. Helen White-Daughter-4249 Walnut St Phila. 4, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic c-v-Renal disease</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Strangulated hernia & necrotic ileum</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:15</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Fisher Jr.</u>		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>3/27/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. William H. Fisher Jr</u>		Medical Center Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 31, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Shad Point Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>R.D.# Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>MAR 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS

1881

WITNESSES

Subscribed and sworn to before me this 1st day of January 1881

Notary Public

My Comm. Expires

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

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3741

CERTIFICATE OF DEATH

03740

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>603 ROSE ST</u>		d. STREET ADDRESS <u>1603 ROSE ST</u>	
3. NAME OF DECEASED (Type or print) First <u>Mittie</u> Middle <u>Williams</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-24-1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>10</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PAUL EVERETT</u>		14. MOTHER'S MAIDEN NAME <u>PRISCILLA ? YELDELA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>Feb</u> , 19 <u>59</u> , that I lost sowing the deceased olive on <u>Jan</u> , 19 <u>59</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>PINEBLUFF RD. Salisbury Md.</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR.</u>		DATE SIGNED <u>3/10/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-15-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREENACRE MEMORIAL PARK</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. STEWART FUNERAL HOME, Salisbury Md.</u> ADDRESS <u>Salisbury Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 17 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8711

WILLIAM BOYD

1/2/40

3-12-20

1/2-20-20

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03741

Reg. Dist. No.

3742

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12614 Westover Circle Salisbury, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>614 Westover Circle</u>		d. STREET ADDRESS <u>614 Westover Circle</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond</u> First <u>Wilson</u> Middle <u>Wilson</u> Last <u>Wilson</u>		4. DATE OF DEATH <u>3-17-</u> 19 <u>59</u> Month <u>3</u> Day <u>17</u> Year <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-41</u>
9. AGE (in years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Orto Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Ella Locker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>231-09-1551</u>	
17. INFORMANT <u>Harriet Ella</u>		Address <u>Ella</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Uremia</u> (a), stating the underlying cause lost. (c) <u>Hydronephrosis-Prostatic Hypertrophy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
INTERVAL BETWEEN ONSET AND DEATH Hours <u>600.0</u> Days <u>0</u> Years <u>0</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REINQUA (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-22-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Berkley MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. M. J. Smith</u>		24a. REC'D BY REGISTRAR <u>APR 1 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Paula S. Howard</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
BATHING

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

87-43

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

NAME: John
AGE: 45
SEX: Male
RACE: White
DATE OF DEATH: 10-15-1910
PLACE OF DEATH: Home
CAUSE OF DEATH: Heart Disease
MANNER OF DEATH: Natural
SIGNATURE: [Signature]
DATE: 10-15-1910

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3743

CERTIFICATE OF DEATH

03742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle William Last Wilson, Sr.		4. DATE OF DEATH Month March Day 25 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-25-1871
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinest		10b. KIND OF BUSINESS OR INDUSTRY Pumps	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Wilson		14. MOTHER'S MAIDEN NAME Agnes Bacon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 116-09-3511	
17. INFORMANT Mrs. Mary Welcker, Oxford, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X Cardiovascular renal disease DUE TO (b) 2 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-19-57 , 19____, to 3-25-59 , 19____, that I last saw the deceased alive on 3-24 , 19 57 , and that death occurred at 10:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Main St., Salisbury, Md. DATE SIGNED			
ACTUAL SIGNATURE Philip A. Insley M.D.		PHYSICIAN'S NAME (Type) Dr. Philip A. Insley Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/28/59	
22c. NAME OF CEMETERY OR CREMATORY Wm. Lee's Crematory		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		24a. REGISTERED BY Norman F. Baker	
24b. REGISTERAR'S SIGNATURE Arthur S. Pomeroy		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death	
John Doe		Male		35		1950		10:00 AM	
6. Place of death		7. Cause of death		8. Manner of death		9. Physician		10. Signature of physician	
Home		Heart Disease		Natural		Dr. Smith		[Signature]	
11. Burial place		12. Name of funeral home		13. Name of undertaker		14. Name of cemetery		15. Name of burial place	
Cemetery		Funeral Home		Undertaker		Cemetery		Burial Place	
16. Name of informant		17. Address of informant		18. Telephone number		19. Signature of informant		20. Date of report	
Informant		123 Main St		555-1234		[Signature]		1950	